Helen Johnson
10823

MIGRANT HEALTH ACT

Congressional Intent as Expressed in Revised Law and Other Official Documents

The revised Migrant Health Act extends the Program for three years to June 30, 1973, makes the Secretary of DHEW rather than the Surgeon General of the Public Health Service responsible for program administration, and increases the annual authorized appropriations to $20 million in fiscal year 1971, $25 million in fiscal year 1972, and $30 million in fiscal year 1973. The intent of Congress as shown by statements in various documents is not necessarily to discontinue the program at the end of three years, but rather to re-assess the situation and determine at that time whether the program is still needed.

The revised Act modifies past legislation in two respects: it adds provision for services to nonmigrants under specified conditions, and requires community participation including migrant consumers of service in program development and implementation. In addition it places greater emphasis on the training of subprofessional aides (allied health personnel) and on maintaining continuity of services as migrants move from area to area.

Other official documents (reports on the legislation, the hearings, and statements on the House and Senate floor) help to clarify the intent of Congress with respect to the above and other items. The following outlines Congressional intent as revealed by pertinent documents.

Above material was presented to Migrant Health Project Review Committee meeting, February 1970.

1. Target population to receive services

The major target population continues to be domestic agricultural migratory workers and their families.

Nonmigrant seasonal farm workers and families who live and work with migrants may also receive the same services as migrants if the Secretary considers this necessary in order to serve migrants effectively.

Special reference was made in floor discussion to environmental health services which cannot be provided effectively solely for migrants in places where the people are closely intermingled with nonmigrants.

Special reference was also made to home-base areas as places where migrants and nonmigrants live and work in the same setting and cannot readily or logically be differentiated.

2. Community participation in program planning and implementation

The Secretary must be satisfied that opportunity for such participation is present before approving a project.

Purposes:

Program development including assessing migrants' health needs and developing necessary resources.

Program implementation.

The requirement applies to new programs and modifications of existing programs.

The community participants involved must include persons broadly representative of --

The population to be served.

Others in the community knowledgeable about migrants' needs.

3. Continuity of services

State and local areas contribute, but problem is national in scope and requires a national approach to its solution.
No local area or State, working alone, can attack a problem.

Inter-area referrals are an important method of providing continuity of care.

4. Training

Purpose of new emphasis on training of subprofessional workers (allied health personnel)

To develop new sources of personnel to supplement available professional health manpower.

To develop better liaison with migrants.

To interpret needs and program in both directions--to the consumer of service and to the provider.

Persons to be trained--emphasis was placed on recruitment from among migrants and ex-migrants.

Emphasis is to be continued on the orientation of professional health workers employed by projects so that they will understand migrants and become migrant advocates. The need for similar orientation of volunteer workers was mentioned.

(Note: In addition to the emphasis on the training of new subprofessionals, one person stressed the importance of using subprofessionals already trained--specifically medical corpsmen returning from military service.)

5. Special needs to be met with expanded program

There is a need to serve migrants in 600 additional counties, each with an influx of 100 or more migrants. (There was recognition of the inadequacy of funds to meet the total need.)

There is a need to provide more adequate services in areas where projects now operate; specifically mentioned were:

Medical and dental services, and the establishment of more family health service centers.

Nutrition counselling including access to food stamps and authorization of food to meet emergencies.

Patient transportation.

Post-hospital follow-up.

Health education.

Field sanitation services.

6. Use of migrant health grant funds (To pay part of cost of project services)

Costs of services to nonmigrants and responsibilities assumed for nonmigrants should be transferred to appropriate local bodies whenever possible.

The allocation of migrant health grant funds should not be done in a way that will replace or discourage present or expanded effort by any State, county or municipal body to provide health services to migrants.

In providing services under the Migrant Health Act, under all circumstances, all other resources should be exhausted.

7. Eligible applicants for migrant health grant funds continue to be either public or private nonprofit organizations, institutions and agencies.

8. The responsibility of the administering agency continues in terms of encouraging and cooperating in programs for the purpose of improving health services for or otherwise improving the health conditions of domestic agricultural migratory workers and their families.

Note: The Migrant Health Act (PL 91-209) was signed by President Richard Nixon on March 12, 1970.

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by Congressman Gray, H.R. 5195 or one of the similar pension bills that would assure the veteran at least partial financial assistance for his service during World War I.

At the meeting of your National Legislative Committee, February 18–19, 1969; in a question and answer period with the Staff Director of the House Veterans Affairs Committee, I called attention to the benefits granted by our Government to those on welfare and asked why, in view of the Presidents U.S. Advisory Commission Report, the veteran should not expect these recommendations to be enacted into law. This was his answer and is a direct quote from the minutes of this meeting:

"This is one of the most serious problems facing us. Here's what's happened. The veterans' programs have been straight-laced: it is business-like, and we like it that way, but in the last 5–7 years, we have had free programs coming up all around us. Free medicine, free dental care, and etc. Then we take a look at our veterans' programs. This is a problem to us. How do you keep these veterans' programs in philosophy, purpose and intent, abreast of the times."

So I conclude my remarks with this question: Should we pursue the program for a separate and distinct pension for all who served in World War I or should we confine our efforts and concentrate on Recommendation No. 17, in order to provide at least the benefits given those on public assistance for our members in similar circumstances for a decent standard of living, with the full understanding that these benefits will be administered and provided by the Veterans Administration.

Now my friends, I dispute the statement that we who served in World War I are the forgotten veteran. The numerous bills introduced in Congress each year, with little or no final action, will bear me out. But I do contend that the lack of legislation for the veterans of World War I, compared with that given veterans who served in other wars, certainly proves that the veteran of World War I and his dependents are the neglected veterans.

S. 2660—INTRODUCTION OF THE MIGRANT WORKER HEALTH AMENDMENTS OF 1969

Mr. YARBOROUGH. Mr. President, for the Nation as a whole, 900 counties furnish seasonal homes, or work areas—or both—for an estimated 1,000,000 migrant farm workers and their dependents. About one-fifth of the Nation's total migrants live seasonally in 117 counties of Texas, and go out from Texas, their homeland, to work the fields in other States.

For a variety of reasons, migrant farm workers and their families are the group most likely to be bypassed by national health gains. They are poor, live in inadequate housing, are often geographically isolated, belong to various minority groups—chiefly Mexican-American and Negro—and frequently lack knowledge of good health practices and of community health resources.

The "channels" to gain access to health care frighten and confuse them, for they fear the sterile atmosphere of the typical clinic or hospital. Moreover, their constant movement hinders continuity of the county services they do receive. Many of their temporary communities look upon them as transients for whom the community feels no responsibility. These communities often lack enough physicians, dentists and nurses to meet the needs of local residents, let alone the needs of people "just passing through."

The result is a heavy burden of illness and disability. Tuberculosis is 17 times more frequent and infestation with worms 35 times more frequent among migrants than among ordinary patients. Mortality from tuberculosis and other infectious diseases is 2½ times the national average. Mortality from accidents is nearly three times the national average. Infant mortality is at the national rate of 20 years ago. As late as 1966, in two Texas border counties—Cameron and Hidalgo—which are home for many thousands of Mexican-American migrants, 20 percent of the births occurred outside of hospitals, compared with 2 percent for the Nation as a whole.

The Migrant Health Act was passed to help meet migrants longstanding health needs. The act authorizes the Public Health Service to grant funds to public or private nonprofit agencies to pay part of the costs of migrant family health service clinics and services to improve migrants' health conditions.

A typical grant-assisted project is operated in a northwestern Ohio county with a seasonal influx of 4,000 members of Texas-based Mexican-American families. The people start coming in April and some stay until November. At the season's peak, twice weekly family health service clinics, held in the evening, provide remedial treatment for men, women and children. The clinics also provide immunizations, family planning, prenatal and postnatal care, and general health counseling. The clinic sessions are held in a remodeled dwelling to which people from surrounding camps have convenient access. Volunteers provide transportation for those who need it.

Each weekday, a nurse is on duty at the clinic headquarters. She refers emergencies to local physicians between clinic sessions. She also makes referrals to local dentists. In addition, she follows up on services given in the evening clinics under standing orders, changing dressings, giving medications, and advising individuals and groups on such problems as diabetic care, prenatal care, and diet.

When the Migrant Health Act was first passed in 1962, organized systems to extend community health services to migrants were extremely rare. Not more than a half-dozen existed in the entire Nation. Now, the Public Health Service informs me that 118 single- and multi-county projects assisted by migrant health grants serve migrants in 317 counties in 36 States and Puerto Rico; 170 hospitals and nearly 1,000 physicians are involved. Of the estimated 300,000 migrants living in project areas for at least brief periods during 1968, 110,000 received medical care and 3,400 were hospitalized. A widely used interarea referral system helped avoid duplications and gaps in services as people moved.

So the work is well begun. However, the potential of the program is far from reached at the present time.

Medical services must be expanded and improved. The present family clinics are swamped with patients at the season's peak. Nearly 600 counties, each with an influx of 100 or more migrants, still lack a system for getting care to the people. What care migrants receive in most of these counties is sporadic, crisis-oriented, and unrelated to care obtained elsewhere.

A similar need exists for expanding dental services. Some project counties have no resident dentist. Little more than emergency extractions are provided for adults in most existing project areas. Some projects provide no dental care for either adults or children. Hospital services are lacking in about half of the projects and limited in many others.

Many projects have recognized some of these unmet needs but continued grant assistance has had to be scaled down to the funds available, regardless of the merit of proposals for expanded service. A backlog of approved projects to extend services to new areas, and approval requests for project increases, is constantly on hand, with no possibility of providing grant assistance. Nor can the present policy of discouraging new proposals be changed without a substantial increase in the annual authorizations for appropriations.

At the present appropriation level of $8 million, the amount available nationally per migrant is $8. Even when contributions from other than migrant health grant sources are added, the total per migrant is little more than $12. This can be compared with the national average per capita health expenditure of over $200.

Therefore, I am introducing today legislation which would extend the Migrant Health Act for 5 years and increase the appropriation authorizations from $15 million in 1970 to $40 million in 1975. The extension and the increases are absolutely necessary if we are ever to meet such great needs.

Mr. President, I ask unanimous consent that a copy of the text of the bill be printed in the RECORD at this point.

The PRESIDING OFFICER. The bill will be received and appropriately referred; and, without objection, the bill will be printed in the RECORD.

The bill (S. 2660), to extend and otherwise amend certain expiring provisions of the Public Health Service Act for migrant health services, introduced by Mr. YARBOROUGH (for himself and other Senators), was received, read twice by its title, referred to the Committee on Labor and Public Welfare, and ordered to be printed in the RECORD, as follows:

S. 2660

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 "$9,000,000 each for the fiscal year ending June 30, 1968, and the next fiscal year, and $15,000,000 for the fiscal year ending June 30, 1970", and inserting in lieu thereof "not to exceed $15,000,000 for the fiscal year ending June 30, 1970, $20,000,000 for the fiscal year ending June 30, 1971, $25,000,000 for the fiscal year ending June 30, 1972, $30,000,000 for the fiscal year ending June 30, 1973, $35,000,000 for the fiscal year ending June 30, 1974, and $40,000,000 for the fiscal year ending June 30, 1975".

Calendar No. 613

91ST CONGRESS
1ST SESSION

S. 2660

[Report No. 91-618]

IN THE SENATE OF THE UNITED STATES

JULY 18, 1969

Mr. YARBOROUGH (for himself, Mr. CRANSTON, Mr. EAGETON, Mr. HUGHES, Mr. JAVITS, Mr. KENNEDY, Mr. MONDALE, Mr. MURPHY, Mr. NELSON, Mr. PELL, Mr. PROUTY, Mr. RANDOLPH, and Mr. WILLIAMS of New Jersey) introduced the following bill; which was read twice and referred to the Committee on Labor and Public Welfare

DECEMBER 18 (legislative day, DECEMBER 16), 1969

Reported by Mr. YARBOROUGH, with amendments

[Omit the part struck through and insert the part printed in italic]

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 "$9,000,000 each for the fiscal year ending June 30, 1968, and the next fiscal year, and $15,000,000 for the fiscal year ending June 30, 1970", and inserting in lieu thereof "$15,000,000 for the fiscal year ending June 30, 1970, $20,000,000 for the fiscal

year ending June 30, 1971, $25,000,000 for the fiscal year ending June 30, 1972, *and* $30,000,000 for the fiscal year ending June 30, ~~1973, $35,000,000 for the fiscal year ending June 30, 1974, and $40,000,000 for the fiscal year ending June 30, 1975".~~ *1973".*

SEC. 2. Section 310 of the Public Health Service Act is further amended by adding immediately after the final sentence thereof the following new sentence: "For the purposes of assessing and meeting domestic migratory agricultural workers' health needs, developing necessary resources, and involving local citizens in the development and implementation of health care programs authorized by this section, the Secretary must be satisfied, upon the basis of evidence supplied by each applicant, that persons broadly representative of all elements of the population to be served and others in the community knowledgeable about such needs have been given an opportunity to participate in the development of such programs, and will be given an opportunity to participate in the implementation of such programs."

Calendar No. 613

91ST CONGRESS
1ST SESSION

S. 2660

[Report No. 91–618]

A BILL

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

By Mr. YARBOROUGH, Mr. CRANSTON, Mr. EAGLETON, Mr. HUGHES, Mr. JAVITS, Mr. KENNEDY, Mr. MONDALE, Mr. MURPHY, Mr. NELSON, Mr. PELL, Mr. PROUTY, Mr. RANDOLPH, and Mr. WILLIAMS of New Jersey

JULY 18, 1969
Read twice and referred to the Committee on Labor and Public Welfare

DECEMBER 18 (legislative day, DECEMBER 16), 1969
Reported with amendments

91ST CONGRESS
1ST SESSION

H. R. 13432

IN THE HOUSE OF REPRESENTATIVES

AUGUST 11, 1969

Mr. ROGERS of Florida introduced the following bill; which was referred to the Committee on Interstate and Foreign Commerce

A BILL

To amend the Public Health Service Act to extend the program of assistance for health services for migrant agricultural workers, to provide assistance for health services for other seasonal agricultural 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 (a) section 310 of the Public Health Service Act (42 U.S.C. 242h) is amended (1) by striking out "and" after "next fiscal year," and (2) by inserting "June 30, 1970," the following: "$30,000,000 for the fiscal year ending June 30, 1971, $45,000,000 for the fiscal year ending June 30, 1972, and $60,000,000 for the fiscal year ending June 30, 1973,".

(b) Such section is further amended (1) by striking out "domestic agricultural migratory workers" each place it appears and inserting in lieu thereof in each such place "migrant and other seasonal agricultural workers", and (2) by striking out "such migratory workers" and inserting in lieu thereof "such workers".

(c) Such section is further amended by striking out "to improve health services for and the health conditions of" in clause (1) (ii) and inserting in lieu thereof "to improve and provide a continuity in health services for and to improve the health conditions of".

(d) Such section is further amended by inserting "(including allied health professions personnel)" after "training persons" each place it appears in clause (1).

91ST CONGRESS
1ST SESSION

H. R. 13432

A BILL

To amend the Public Health Service Act to extend the program of assistance for health services for migrant agricultural workers, to provide assistance for health services for other seasonal agricultural workers, and for other purposes.

By Mr. ROGERS of Florida

AUGUST 11, 1969

Referred to the Committee on Interstate and Foreign Commerce

H R 14733
1969-1970

91ST CONGRESS } HOUSE OF REPRESENTATIVES { REPORT
1st Session } { No. 91-711

House Rept

HEALTH SERVICES FOR DOMESTIC AGRICULTURAL MIGRANTS

DECEMBER 9, 1969.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. STAGGERS, from the Committee on Interstate and Foreign Commerce, submitted the following

REPORT

[To accompany H.R. 14733]

The Committee on Interstate and Foreign Commerce, to whom was referred the bill (H.R. 14733) to amend the Public Health Service Act to extend the program of assistance for health services for domestic migrant agricultural workers and for other purposes, having considered the same, report favorably thereon without amendment and recommend that the bill do pass.

PRINCIPAL PURPOSE OF THE BILL

The bill would extend for an additional 3 years the current program under which health services are provided to domestic agricultural migratory workers.

HEARINGS—COST

Hearings were held before the Subcommittee on Public Health and Welfare on September 29, 1969. Testimony in support of this legislation was presented by representatives of the Department of Health, Education, and Welfare and the American Public Health Association. Statements in support of this legislation were filed by the American Hospital Association, the Association of State and Territorial Health Officers, and the Shade Tobacco Growers Agricultural Association, Inc. After the hearings and subcommittee executive session consideration of the subject, the bill was introduced as a clean bill, and reported without amendment.

The appropriation authorizations contained in the bill are shown in the following table:

New obligational authority

[In millions]

Section 310—Domestic agricultural migrants:	
1971	$20
1972	25
1973	30

Summary of the Bill

In 1962, the Congress enacted legislation providing for grants for family health service clinics and other health services for domestic agricultural migratory workers and their families. The current program expires June 30, 1970, and the bill (H.R. 14733), as introduced, extends this program for an additional 3 years. Appropriation authorizations under the program were for $3 million for each of the first 3 fiscal years of the program beginning with fiscal year 1963, to $7 and $8 million for fiscal years 1966, 1967 to $9 million for fiscal years 1968, 1969 and $15 million for 1970. The cost estimates submitted by this bill were for $30 million requested for 1971, $45 million for 1972, and $60 million for 1973. As reported, the bill authorizes $20 million for 1971, $25 million for 1972, and $30 million for 1973. The Department of Health, Education, and Welfare, although supporting the bill in principle, recommended that the extension be for 2 years instead of 3 years.

This bill amends section 310 of the Public Health Service Act to broaden the definition of program beneficiaries to include other seasonal agricultural workers if such provision will contribute to the improvement of health conditions of the migratory farmworkers and their families. This section is further amended by striking out "to improve health services for and the health conditions of" and inserting in lieu thereof "to improve and provide a continuity in health services for and to improve the health conditions of." It also includes an amendment of the language authorizing the use of grant funds for training by specifying the inclusion of allied health personnel, and a technical amendment.

Justification of the Bill

The health needs of agricultural migrants are among the greatest of any socioeconomic group in the United States. The migrants have health problems that are similar to, but more severe than, those of stable rural farmworker families. Studies continue to show high infant mortality rates, high communicable disease rates, low prenatal care rates, high premature birth rates, high accident rates, low immunization levels, serious need for dental care, low economic and educational levels, mobility and lack of resident status leading to geographic and eligibility isolation from medical facilities, plus cultural factors and language barriers contributing to the health problems of migrant and seasonal agricultural workers and their families.

The need for improved health services for both migratory and seasonal agricultural workers has been recognized by the President's National Advisory Commission on Rural Poverty. The fact, recog-

nized by the Commission as well as by this bill, is that migrant and seasonal farmworkers frequently work and live side by side in the same community. They face much the same problems with regard to obtaining needed health services and care. They and their families endure the same conditions of poverty and poor environment and are victims of many of the same nutritionally based diseases. Their status as seasonal workers and as migrant workers frequently shifts back and forth and it makes no sense to arbitrarily cut off health services of a migrant agricultural worker when his status reverts in some years to that of a nonmigrating seasonal agricultural worker.

The people are poor and cannot afford to purchase the medical care they need. Yet they fail to qualify as legal residents in their temporary work communities and are thus excluded from community services available to other indigent persons. Many communities which need their labor for brief periods have meager health resources which are severely overtaxed by a periodic influx of migrants. In spite of economic dependence on migrant farmworkers, communities have frequently overlooked or excluded migrants from health services. Focused planning will continue to be necessary to serve them. Furthermore, for the migrant, the linking of health services along the path of migration is essential to provide continuity of care. The migrant's health needs cannot be met by one community, State, or region working alone.

The Migrant Health Act was devised to make health care accessible to migrants through helping States and communities adapt their health care system to the migrant's unique situation and need. In striking contrast to the half dozen isolated community efforts of 6 years ago, now 117 single or multicounty grant-assisted projects serve migrants in 35 States and Puerto Rico.

A typical project operates one or more family health service clinics during the season or year round, depending on whether the project serves a work area or a home base where migrants move in and out throughout the year.

The clinic sessions provide desperately needed remedial health care to the migrants at readily accessible times and places. Typically, they are supplemented by arrangements with local physicians or hospital outpatient departments which provide emergency care between clinic sessions. They treat all family members for whatever illnesses, injuries or other needs they present, referring patients for further special care if necessary. The medical services are supported by an active outreach through nurses and aides who visit migrants in their homes for early case finding, health counseling, necessary referral, and posttreatment followup.

Migrant health projects provide not only remedial care to all family members, but also immunizations, family planning services, nutrition counseling, and other health maintenance services. Project staffmembers work with growers and other community groups to improve housing and environmental conditions, and to develop better understanding and acceptance of migrants as people. Finally, they work directly with migrants to teach and encourage good homemaking and safety practices, and to provide better understanding of health services and their effective use.

Nearly 1,000 physicians are now serving migrants through 225 family health service clinics supplemented by care in their own offices

or in hospitals. An estimated 325,000 migrants lived for at least part of the past year in counties served by projects. During the year, 210,000 medical visits and 28,000 dental visits were made and 3,600 migrants were hospitalized. In addition, nurses and aides made 160,000 case-finding and health counseling visits to labor camps, other migrant home sites, schools, and migrant day-care centers.

However, it must be recognized that the number of migrants who still do not receive these benefits is much greater than the number who do receive some service. Of the estimated 1 million agricultural migrants in America, less than one-third received services last year through the migrant health program. Migrants' use of medical care is about one-seventh, their use of dental care is about one-twentieth, and their use of hospital care is about one-fourth that of the general population. Even those who are reached cannot be given more than the barest minimum care because of limited staff and funds. It should be noted here that requests for grant assistance have consistently exceeded available funds from the beginning of the program.

The projects now in operation have largely been developed by careful planning and utilization of a variety of available resources, e.g., Federal, State, and local, public and private. They are encouraging examples of beginning community involvement in planning and development of programs for health. A promising start for innovation in the organization and quality of services for migrants has been shown in the development of these projects, and in the increasing involvement of private volunteer groups in carrying out these projects. However, the neglect of generations, cultural barriers, and the severe and unusual problems found among the migrants cannot be overcome in a few short years. These projects are just now, after a few years, approaching a maturing stage that could improve their capacity for providing adequate services. This bill recognizes the fact that special programs for agricultural migrants must be continued at this point of potential maturation to assure that the migrants are not lost in the shuffle, as they have been in the past, to reach more of the as yet unreached migrants, and to realize the improved level of health services that has now been made an important objective of the program.

Description of the Bill

Subsection (a) of the bill amends section 310 of the Public Health Service Act to extend for 3 years (beginning with fiscal year 1971) the program of assistance for health services for domestic migrant agricultural workers. $20 million is authorized for fiscal year 1971, $25 million for fiscal year 1972, and $30 million for fiscal year 1973.

Under the amendment to section 310 made by subsection (b), the Secretary of Health, Education, and Welfare may use funds appropriated under that section to provide health services to seasonal agricultural workers (and their families) when he finds that the provision of such services will contribute to the improvement of the health conditions of the domestic migrant agricultural workers and their families who may presently receive health services under that section.

The amendments made by subsections (c) and (d) to section 310 make it clear that (1) grant funds under that section may be used for special projects to not only improve the health services for domestic

migrant agricultural workers (including their families) but also to continue health services for such workers; and (2) grant funds used for training personnel to provide health services to such workers may be used to provide training for allied health professions personnel to provide health services to such workers.

Subsection (e) makes two technical amendments to section 310.

Agency Reports

Executive Office of the President,
Bureau of the Budget,
Washington, D.C., October 14, 1969.

Hon. Harley O. Staggers,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D.C.

Dear Mr. Chairman: This is in response to your request of August 12, 1969, for our views on H.R. 13432, a bill to amend the Public Health Service Act to extend the program of assistance for health services for migrant agricultural workers, to provide assistance for health services for other seasonal agricultural workers, and for other purposes.

Dr. Roger O. Egeberg, Assistant Secretary for Health and Scientific Affairs, Department of Health, Education, and Welfare, presented a written statement before your committee on September 29, 1969. For the reason set forth in that statement, we recommend a 2-year extension of section 310 of the Public Health Service Act (42 U.S.C. 242h) to provide health services for migrant agricultural workers. Further, we recommend deletion of specific annual authorizations and the provision of an indefinite authorization to provide greater flexibility in determining the annual program level.

Sincerely yours,

Wilfred H. Rommel,
Assistant Director for Legislative Reference.

Department of Health, Education, and Welfare,
Washington, October 17, 1969.

Hon. Harley O. Staggers,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D.C.

Dear Mr. Chairman: This letter is in response to your request of August 12, 1969, for a report on H.R. 13432, a bill to amend the Public Health Service Act to extend the program of assistance for health services for migrant agricultural workers, to provide assistance for health services for other seasonal agricultural workers, and for other purposes.

The bill would extend for 3 additional years the authorization in section 310 of the Public Health Service Act for project grants to provide health services for migrant farmworkers and their families. The present authorization expires June 30, 1970. For the 3 additional years the bill would authorize appropriations of $30 million for fiscal year 1971, $45 million for 1972, and $60 million for 1973. In addition, the bill includes an amendment to broaden the definition of program beneficiaries to include "other seasonal agricultural workers" and

clarifying amendments relating to the purpose of the grants authorized and to the language authorizing the use of grant funds for the training of allied health personnel.

The views of our Department on this proposed legislation were outlined in testimony presented to your Subcommittee on Public Health and Welfare by Assistant Secretary Egeberg on September 29, 1969. In brief, we recommend that, in lieu of enactment of the provisions of H.R. 13432, the present provisions of section 310 of the Public Health Service Act be extended for 2 additional fiscal years, with an indefinite appropriations authorization—i.e., "such sums as may be necessary."

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

Sincerely,

ROBERT H. FINCH,
Secretary.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

SECTION 310 OF THE PUBLIC HEALTH SERVICE ACT

HEALTH SERVICES FOR DOMESTIC AGRICULTURAL MIGRANTS

SEC. 310. There are hereby authorized to be appropriated 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, $9,000,000 each for the fiscal year ending June 30, 1968, and the next fiscal year, [and] $15,000,000 for the fiscal year ending June 30, 1970, *$20,000,000 for the fiscal year ending June 30, 1971, $25,000,000 for the fiscal year ending June 30, 1972, and $30,000,000 for the fiscal year ending June 30, 1973*, to enable the [Surgeon General] *Secretary* (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 (*including allied health professions personnel*) 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] *to improve and provide a continuity in health services for and to improve the health conditions of* domestic agricultural migratory workers and their families, including necessary hospital care, and including training persons (*including allied health professions personnel*) 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. *The Secretary may also use funds appropriated under this section to provide health services to persons*

(and their families) who perform seasonal agricultural services similar to the services performed by domestic agricultural migratory workers if the Secretary finds that the provision of health services under this sentence will contribute to the improvement of the health conditions of such migratory workers and their families.

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Senate Report

Calendar No. 613

91ST CONGRESS
1st Session

SENATE

REPORT
No. 91-618

MIGRANT HEALTH SERVICES

DECEMBER 18 (legislative day DECEMBER 16), 1969.—Ordered to be printed

Mr. YARBOROUGH, from the Committee on Labor and Public Welfare, submitted the following

REPORT

[To accompany S. 2660]

The Committee on Labor and Public Welfare, to which was referred the bill (S. 2660) to extend and otherwise amend certain expiring provisions of the Public Health Service Act for migrant health services, having considered the same, reports favorably thereon with amendments and recommends unanimously that the bill as amended do pass.

SUMMARY

As reported by the Committee on Labor and Public Welfare, S. 2660 would extend until June 30, 1973, the authority of the Public Health Service Act to improve health services and the health conditions of domestic agricultural migratory workers and their families.

The bill, as amended, would extend the existing program authorized by section 310 of the Public Health Service Act with increased funding authorizations.

AMENDMENTS

As introduced, S. 2660 would have expanded and extended to June 30, 1975, the health services program for migratory agricultural workers that is scheduled to expire on June 30, 1970. The committee agreed that it would be desirable to reexamine this program at an earlier date. Thus, the committee recommends that this program be extended to June 30, 1973.

Recent hearings in Washington and in the Rio Grande Valley of Texas pointed up the need to involve the consumer population in project development and implementation. It is recommended, therefore, that the Secretary must be satisfied on the basis of evidence supplied by each applicant, that persons in the community knowledgeable

about the health needs of migrants and that persons broadly representative of all elements of the population to be served be given an opportunity to participate in the development and implementation of programs to improve migrant health services.

Hearings—Cost

Hearings were held before the Subcommittee on Health in Washington, D.C., on October 21 and 22 and in Edinburg, Tex., on November 24. Testimony favorable to the extension and expansion of the migrant health program was presented by representatives of the Department of Health, Education, and Welfare, the AFL–CIO, the American Medical Association, the American Public Health Association, the Association of State and Territorial Health Officers, church-sponsored organizations, and other groups and individuals. The administration witness testified that the Department of Health, Education, and Welfare supported full funding of the 1970 authorization.

The annual appropriation authorizations shown in the bill are as follows: Section 310—Domestic agricultural migrants:

1971	
1972	$20,000,000
1973	25,000,000
	30,000,000

The Problem

Hundreds of the Nation's communities with an annual influx of migrants still lack an organized program to provide health services to workers and families for the duration of their stay.

Nationwide, the migrant population continues to total approximately 1 million persons, including workers and their families; 900 of the Nation's 3,000 counties are annually temporary homes to numbers ranging from 100 to 40,000 or more.

Every year the migrant health grant funds available are inadequate to respond to the need and requests from communities for grant assistance. As a result, the present program has temporary contact with only about one-third of the Nation's migrants each year.

Contact is made to the extent that the people happen to live or work in the 300 counties which offer personal health care through migrant health projects. Care for migrants in most of the other 600 counties continues to be sporadic and crisis oriented.

Even for the people with whom the program makes contact, the breadth of services is typically less than adequate. Dental care is often limited or entirely lacking. A sampling of the medical conditions among patients reported by migrant health projects during the past year was compared with a sampling of medical conditions among patients seen in private physicians' offices during a comparable period. The sampling of medical conditions among patients seen in private physicians' offices was reported in the National Disease and Therapeutic Index.

The comparison showed that infective and parasitic diseases, diseases of the respiratory system, and digestive system diseases were from two to five times as large a proportion of the total conditions seen among migrants as among the general population. Among the

infective and parasitic diseases, tuberculosis was seen 17 times, venereal disease 18 times, and infestations with worms 35 times as often among migrants as among patients in private physicians' offices.

The need for increased funds is graphically illustrated by comparing statistics that reveal the per capita expenditures of $12 for health care of migrants, compared with the per capita expenditures of over $200 for health care for the Nation as a whole.

Medical and dental services are not the only services that are limited for migrants. Under existing conditions, funds for hospital care are often exhausted by projects before the season is over. Yet project reports show that the use of hospital care by migrants is only about one-fourth that of the general population.

Looking into the future, progress must be made in the coverage of migrants by programs for the general population and improvements in migrants' economic status can be anticipated.

As medicaid and other health programs assume certain costs and responsibilities now assumed by migrant health grants, and as migrants become economically better able to meet their own health needs, the migrant health program may be able to become increasingly a supplement to other programs.

However, for the foreseeable future, the migrant health program must have a separate identity with expanded funds.

While extending this program for 2 years in 1968, the joint conferees from the House of Representatives and the Senate agreed "that this program, because of its importance to the health of the American people, should be considered as a permanent and separately identifiable program, subject to periodic congressional review, and authorization of appropriations."

Notwithstanding the above-stated reasons for continuing and expanding a separate migrant health program, the Public Health Service in late 1968 instituted a reorganization plan that appears to destroy the separate identity and operations of the migrant health program, and obliterate the separate central and regional office staff of the Migrant Health Unit.

The committee, as in 1968, believes that the migrant health program must have a separate identity with permanent staff to administer the program. The committee looks with disfavor upon the 1968 reorganization.

Changes in Existing Law

In compliance with subsection (4) of rule XXIX of the Standing Rules of the Senate, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman) :

PUBLIC HEALTH SERVICE ACT, AS AMENDED

* * * * * * *

TITLE III—GENERAL POWERS AND DUTIES OF PUBLIC HEALTH SERVICE

* * * * * * *

SEC. 310. There are hereby authorized to be appropriated 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, [$9,000,000 each for the fiscal year ending June 30, 1968, and the next fiscal year, and $15,000,000 for the fiscal year ending June 30, 1970.] *$15,000,000 for the fiscal year ending June 30, 1970, $20,000,000 for fiscal year ending June 30, 1971, $25,000,000 for the fiscal year ending June 30, 1972, and $30,000,000 for the fiscal year ending June 30, 1973*, 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 necessary hospital care, and 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. *For the purposes of assessing and meeting domestic migratory agricultural workers' health needs, developing necessary resources, and involving local citizens in the development and implementation of health care programs authorized by this section, the Secretary must be satisfied, upon the basis of evidence supplied by each applicant, that persons broadly representative of all elements of the population to be served and others in the community knowledgeable about such needs have been given an opportunity to participate in the development of such programs, and will be given an opportunity to participate in the implementation of such programs.*

O

Subcommittee on Public Health and Welfare, of which I am chairman, there was unanimous agreement among the witnesses that this program should be continued. We heard of the progress that has been made, since the inception of this grant support, in strengthening the Nation's public health training resources.

Mr. Speaker, during the 10 years that this program has been in effect it has stimulated the expansion and development of schools of public health—in number, in enrollments, and in the degree of technical assistance they have rendered to their communities.

When this program was first authorized in 1958, there were only 11 schools of public health. This year there are 16. In my own State of Oklahoma a new school was accredited in 1967 at the University of Oklahoma. The most recently established school is in a neighboring State—at the University of Texas at Houston; it was accredited this year.

Enrollments in schools of public health have nearly tripled since the beginning of this program.

These support grants to schools of public health have provided an extremely important resource in assisting the schools to meet the challenge of training the professional personnel required for today's changing and expanding community and environmental health programs.

In the decade since these grants have been available, the schools have undergone extensive changes, reorienting their teaching programs to be more acutely attuned to current problems. They are revising their academic programs in keeping with new technologies and new patterns for the delivery of health services.

The schools have responded with a readiness to meet new and emerging health needs—of their communities and of the Nation.

Schools of public health prepare the majority of the graduate public health specialists for services throughout the country. More than 90 percent of graduates enter public service. They hold key posts in local, city, State, national, and international health agencies.

We can take pride in the many accomplishments under this program. Nevertheless, still greater efforts are required.

There are still critical shortages of professional public health manpower. If these shortages are to be alleviated, schools must be strengthened, expanded, and new schools must be encouraged.

The bill which we are considering today extends for 3 years—fiscal year 1971 through fiscal year 1973—the authority of section 309(c) of the Public Health Service Act for these formula grants to schools of public health to assist the schools in providing comprehensive professional public health training, specialized consultative services, and technical assistance in the fields of public health and in the administration of State or local public health programs. The bill would provide appropriation authorizations of $7 million in fiscal year 1971, $9 million in fiscal year 1972, and $12 million in fiscal year 1973.

Schools of public health must continue to improve and expand their programs to meet the tremendous demands of today's health programs.

Costs of education have been rising sharply, and the schools have been struggling under increasing responsibilities. It is likely that before the expiration of this legislation, at least two new schools of public health will be established. The increases in funding which this bill authorizes are necessary to sustain and expand the efforts of the present schools and at the same time to assist the new schools in undertaking their responsibilities.

The formula grant has proved an effective mechanism for providing the schools of public health—and hence the Nation—with the means to improve and expand public health training to meet the requirements of changing and emerging health problems.

The continuation of this program of assistance to schools of public health is important to the national effort to increase and improve the health resources of this Nation. I urge the enactment of H.R. 14790.

The SPEAKER. The question is on the motion of the gentleman from West Virginia that the House suspend the rules and pass the bill H.R. 14790, as amended.

The question was taken; and (two-thirds having voted in favor thereof) the rules were suspended and the bill, as amended, was passed.

A motion to reconsider was laid on the table.

Mr. STAGGERS. Mr. Speaker, I ask unanimous consent for the immediate consideration of a similar Senate bill (S. 2809) to amend the Public Health Service Act so as to extend for an additional period the authority to make formula grants to schools of public health, project grants for graduate training in public health, and traineeships for professional public health personnel.

The Clerk read the title of the Senate bill.

The SPEAKER. Is there objection to the request of the gentleman from West Virginia?

There was no objection.

The Clerk read the Senate bill, as follows:

S. 2809

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That section 309(c) of the Public Health Service Act is amended by striking out "$5,000,000 for the fiscal year ending June 30, 1968, $6,000,000 for the fiscal year ending June 30, 1969, and $7,000,000 for the fiscal year ending June 30, 1970" and inserting in lieu thereof: "$7,000,000 for the fiscal year ending June 30, 1970, $9,000,000 for the fiscal year ending June 30, 1971, $12,000,000 for the fiscal year ending June 30, 1972, $15,000,000 for the fiscal year ending June 30, 1973, $18,000,000 for the fiscal year ending June 30 1974, and $20,000,000 for the fiscal year ending June 30, 1975".

SEC. 2. Section 309(a) of the Public Health Service Act is amended by striking out "and $12,000,000 for the fiscal year ending June 30, 1971" and inserting in lieu thereof: "$15,000,000 for the fiscal year ending June 30, 1971, $18,000,000 for the fiscal year ending June 30, 1972, $21,000,000 for the fiscal year ending June 30, 1973, $24,000,000 for the fiscal year ending June 30 1974, and $27,000,000 for the fiscal year ending June 30, 1975".

SEC. 3. Section 306(a) of the Public Health Service Act is amended by striking out "and $14,000,000 for the fiscal year ending June 30, 1971" and inserting in lieu thereof: "$14,000,000 for the fiscal year ending June 30, 1971, $18,000,000 for the fiscal year ending June 30, 1972, $22,000,000 for the fiscal year ending June 30, 1973, $26,000,000 for the fiscal year ending June 30, 1974, and $30,000,000 for the fiscal year ending June 30, 1975".

MOTION OFFERED BY MR. STAGGERS

Mr. STAGGERS. Mr. Speaker, I offer a motion.

The Clerk read as follows:

Mr. STAGGERS moves to strike out all after the enacting clause of S. 2809 and insert in lieu thereof the provisions of H.R. 14790, as passed by the House.

The motion was agreed to.

The Senate bill was ordered to be read a third time, was read the third time, and passed, and a motion to reconsider was laid on the table.

A similar House bill (H.R. 14790) was laid on the table.

HEALTH SERVICES FOR DOMESTIC AGRICULTURAL MIGRANTS

Mr. STAGGERS. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 14733) to amend the Public Health Service Act to extend the program of assistance for health services for domestic migrant agricultural workers and for other purposes.

The Clerk read as follows:

H.R. 14733

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That (a) section 310 of the Public Health Service Act (42 U.S.C. 242h) is amended (1) by striking out "and" after "next fiscal year," and (2) by inserting after "June 30, 1970," the following: "$20,000,000 for the fiscal year ending June 30, 1971, $25,000,000 for the fiscal year ending June 30, 1972, and $30,000,000 for the fiscal year ending June 30, 1973,".

(b) Such section is further amended by adding at the end thereof the following new sentence: "The Secretary may also use funds appropriated under this section to provide health services to persons (and their families) who perform seasonal agricultural services similar to the services performed by domestic agricultural migratory workers if the Secretary finds that the provision of health services under this sentence will contribute to the improvement of the health conditions of such migratory workers and their families."

(c) Such section is further amended by striking out "to improve health services for and the health conditions of" in clause (1) (ii) and inserting in lieu thereof "to improve and provide a continuity in health services for and to improve the health conditions of".

(d) Such section is further amended by inserting "(including allied health professions personnel)" after "training persons" each place it appears in clause (1).

(e) Such section is further amended (1) by striking out "Surgeon General" and inserting in lieu thereof "Secretary", and (2) by inserting at the beginning of such section the following heading:

"HEALTH SERVICES FOR DOMESTIC AGRICULUTRAL MIGRANTS"

The SPEAKER. Is a second demanded?

Mr. SPRINGER. Mr. Speaker, I demand a second.

The SPEAKER. Without objection, a second will be considered as ordered.

There was no objection.

Mr. STAGGERS. Mr. Speaker, This bill was reported unanimously by the committee, and would extend for 3 years the current program under which health services are provided to domestic agricultural migratory workers. This program has been in effect since 1962, and today covers approximately one-third of the approximately 1 million domestic agricultural migratory workers and their families.

The health needs of agricultural migrants are among the greatest of any group in the United States. In general, these Americans, as a group, have abnormally high infant mortality rates, high rates of communicable disease, high accident rates, and, in general, more health problems than almost any other group. As they follow the crops through the United States, they go from one community to another, and since they are nonresidents, do not qualify for many health programs provided by local communities but limited to residents. In addition the health facilities available in many of these areas which depend on the labor of these migrants are relatively meager. This legislation is designed to fill the gap in health services for these people, by providing grants which, in general, cover about 40 percent of the costs of providing health services for these migrants and their families.

Current law limits the services furnished to persons who are migrants; however this distinction turns out to be quite arbitrary in many cases since the status of a person as a migrant frequently shifts back and forth.

The bill, therefore, expands coverage of the program somewhat to permit the furnishing of health services to persons who are seasonal agricultural workers if the furnishing of these services will contribute to the improvement of health conditions of migrants and their families.

The bill authorizes a total of $55 million in appropriations over the next 3 fiscal years, and was supported by all witnesses at the hearings. The committee was unanimous in ordering the bill reported to the House, and we recommend its passage.

[Mr. STAGGERS addressed the House. His remarks will appear hereafter in the Extensions of Remarks.]

(Mr. SPRINGER asked and was given permission to revise and extend his remarks.)

Mr. SPRINGER. Mr. Speaker, since 1962 the Federal Government has been assisting local governments maintain health programs designed to meet the problems caused by the yearly influx of migratory workers. Health facilities and personnel are usually swamped by this sudden flood of people creating extraordinary demands for health services. Since starting this program with a handful of communities participating there are now 117 such projects in 35 States.

In addition to ordinary, in the field, health assistance the act was expanded to include emergency hospital services in recognition of the fact that many migrant workers will have dire need for hospital treatment and no way to get it unless it is available free or at a minimal cost. Community hospitals cannot bear the brunt of this demand alone.

In the bill now before us recognition is made of another factor which affects the whole problem and which we have not dealt with until now. Migrant workers not only have a great need for health care and tax the local facilities beyond endurance but they also bring with them in many instances diseases and other health conditions which then affect all of the seasonal workers in the area, whether migrant or local. Also a migrant worker may not always be migrant. Seasonal employment can be a way of life for many people who do not move about or at least do not move very far. When acute health problems attack seasonal workers it is not easy and probably not desirable to sort out those who will be treated under one set of rules and those who happen to arrive on a truck to be treated under a different set. H.R. 14733 allows use of funds to provide health services to seasonal—as opposed to migrant—workers when doing so will contribute to improvement of conditions for migrants.

More and more communities are coming to realize that providing health care for migrant workers is a direct contribution to the public health of an entire community. It is not easy to overcome generations of neglect combined with cultural barriers. The health standards of a large shifting group of our population must be raised gradually. It takes time but this program, which by comparison with most health programs brought here for consideration, is extremely modest and is making a significant impact on the problem. It is also one which requires community desire and community involvement if it is to succeed.

The bill before us would extend the program for 3 years and provide funds as follows: for 1971, $20 million; for 1972, $25 million and for 1973, $30 million.

I recommend the bill to the House.

Mr. ROGERS of Florida. Mr. Speaker, I rise in support of H.R. 14733, which would amend the Public Health Service Act to extend the program of assistance to the States for health services for migrant agricultural workers and to provide assistance for health services for other seasonal agricultural workers.

This legislation would extend the existing programs for 3 fiscal years at the following levels of authorization: $20 million for 1971; $25 million for 1972, and $30 million for 1973.

In addition, the scope of the present law is expanded to include persons—and their families—who perform seasonal agricultural services similar to the services performed by domestic agricultural migratory workers if the Secretary of Health, Education, and Welfare finds that such health services will improve the health conditions of migrant workers and their families.

In many instances, Mr. Speaker, the nonmigrant agricultural worker works side by side with the migrant worker. Yet, the nonmigrant often does not receive health care through the municipal, county, or State government; and likewise, he is ineligible for assistance from the Federal Government. The migrant worker and his family may receive good health care through the migrant health services program only to become exposed again to disease from the uncared for nonmigrant agricultural worker. Too, the nonmigrant may decide at the end of the season to move with the work force, as sometimes happens, thus making it difficult to distinguish the migrant from the nonmigrant.

It was the feeling of the committee that both the migrant worker and his family as well as the nonmigrant worker and his family could be served by expanding the scope of the bill and permitting the Secretary of Health, Education, and Welfare to determine when such additional health services should be provided.

We are making good progress under this program which was first enacted in 1962 as Public Law 87-692. At that time, there were only about one-half dozen isolated community programs in operation. There are now 117 single or multicounty, grant-assisted projects serving migrants in 35 States and Puerto Rico.

An estimated 325,000 migrants live in the counties served by such projects. As of June 30 of this year, 1,000 physicians were serving in the program; there were, in fiscal year 1969, 210,000 medical visits, 28,000 dental visits, and 3,600 migrants were hospitalized.

Yet, there is much more that needs to be done. We are reaching only about one-third of the total migrant population, estimated to be about 1 million. Over 600 counties where migrants live temporarily still have no grant-assisted services.

When I introduced the bill in August of this year to extend the program for 3 years, I recommended a funding authorization of $30 million for 1971; $45 million for 1972, and $60 million for 1973.

In testimony before the subcommittee, the administration indicated that it wanted only a 2-year extension of the program with an authorization of $20 million for 1972 and $25 million for 1972.

I believe we must do more, and can do more. The funding of this program has not been encouraging. As a nation we spend $250 per person per year on health care; last year, we spent $12 per migrant worker, including local support.

Although the authorization for 1970 is $15 million, the House-passed appropriation bill contains only $8 million for this program, or about $8 for every migrant and dependent in the Nation.

The Senate Appropriation Committee has increased this amount to $15 million and I am hopeful that the Senate will keep the higher figure.

I urge approval of the legislation before the House at the present time, H.R. 14733, and I am likewise hopeful that an increased authorization for this measure can be obtained.

Mr. JARMAN. Mr. Speaker, this bill (H.R. 14733) provides for a 3-year extension of the migrant health program with an authorization level of $20 million for 1971, $25 million for 1972, and $30 million for 1973. This bill also broadens the

definition of the program beneficiaries to include other seasonal agricultural workers.

In passing the Migrant Health Act, Congress recognized the obstacles faced by domestic migratory farmworkers and their families in obtaining health care. The migrant families share the health problems typical of other low-income minority groups who live in poor housing, lack education, and lack knowledge of good health concepts and practices. Added to these problems are the ones created by their mobility—lack of attachment to any one community, frequent rejection by the same communities that depend on their labor, and transiency which restricts their access to the health services made available to needy community residents. In addition, community health services are often provided at times which conflict with the migrants' work schedule and at urban centers usually far removed from the places where they work or live temporarily.

The migrant families are poor and cannot afford to purchase the medical care they need. In addition, many communities which need their labor for brief periods have meager health resources which are severely overtaxed by a periodic influx of migrants. As a result of long-term neglect, the health needs of migrants far exceed those of the general population.

The total migrant population is estimated at approximately 1 million persons including workers and their families. During each 12-month period, they work and live for several months in more than 900 of the Nation's 3,000 counties.

The migrant health projects have demonstrated that interest in meeting the health needs of migrant families exists in many communities across the Nation; and that States and communities are ready and willing to put forth effort and funds to make health services accessible to a temporary influx of migrants if they are encouraged to do so by the availability of outside financial and technical assistance in meeting a problem that no single State or community can meet alone.

These grant-assisted projects are community-based in the fullest sense of the term. The philosophy of the program is to encourage and to help the community recognize and assume its responsibility to include migrants in its planning and provision of health services, making whatever adaptations are necessary to serve them effectively. These projects are not demonstration or pilot projects. They provide urgently needed direct medical care to migrant farmworkers and their families.

Family health service clinics, serviced by nearly 1,000 physicians, are operating seasonally or year round in more than 225 locations in or near large concentrations of migrant workers and families. Last year, migrants made 210,000 visits to project physicians, and 23,000 visits to project dentists. In addition, nurses made 160,000 case-finding and health counseling visits to labor camps, other migrant home sites, schools, and migrant day-care centers. Projects have working agreements with 170 community hospitals in which over 3,600 migrants were hospitalized. Inter-project communication systems are being established to provide a capacity for continuity of care for migrant people as they move from place to place.

The program stresses flexibility in the scheduling of services to make them available at times and places where they can be effectively used. Physicians and nurses drive many miles, often over rough roads, to hold night clinics at points where migrants are concentrated. Health aides, recruited from the migrant community, work in the camps to interpret the service to those unaccustomed to seeking and using medical care.

In some localities, the number of migrants is small and they are widely scattered. In lieu of formal clinics, the project may set up a nursing program for regular camp visits for casefinding, referral of migrants to local physicians' offices, and arrangements for patient transportation, if necessary. This type of referral arrangement is often used to supplement family health clinics by providing services between clinic sessions.

Although progress is continually being made in the provision of health services to migrants, it is estimated that in the past year, health services reached only about one out of every three migrant workers. And they were reached typically for only about 3 to 6 months of the year. Even for the people with whom the program makes contact, the services are typically less than adequate. Dental services, especially for adults, remain a large area of almost untouched need. Preventive services, including systematic health evaluation of all patients seen by a project to determine evidence of hidden disease, must be given lower priority than care for immediate acute needs, and funds for support of hospitalized patients are often exhausted before the season is over.

Moreover, the overcrowded family health service clinics in some project areas testify to the need for better-staffed and more frequent clinic sessions. The family health service clinics, helpful as they have been, often operate in primitive facilities with primitive equipment. They are often understaffed and the physicians and nurses find themselves on a treadmill, treating symptoms without time or opportunity for doing much more.

From reports received from the projects, it is evident that growth in scope of service and geographic coverage are greatly needed. Local communities and States are willing and ready to assume part of the cost and the responsibility. They are beginning to find effective ways to relate the services of one project area to those in other areas where the same migrants are served, in order to provide increasing continuity of services for this population.

To meet the continuing needs of the Nation's migrants at a level more commensurate with their health problems requires continuation of the Migrant Health Act and substantially increased funds. The number of counties in which migrants have access to project services should be increased, with the expansion of geographic coverage concentrated on home-base and important "upstream" areas. More physicians and dentists should be employed for longer periods in existing and in new project areas.

Casefinding and followup care as migrants move from one county to another should be strengthened by adding more nurses and aides for field visiting to identify and bring migrants under care. The utilization of aides as intermediaries between the migrants and the professional health worker should be continued and expanded, in order to provide the migrant with greater opportunity to learn to accept responsibility for appropriate health action on his own behalf.

There is also need to extend services to other needy seasonal farmworkers and their families, who often live side by side with migrants, who share most of their handicaps except for mobility, and many of whom have migrated in the past and may again in the future. These seasonal farmworkers and their families form the core group in home-base areas from which the migrant population is drawn. There it is almost impossible to determine who is and who is not a migrant. The people themselves may decide to migrate one year and not the next.

The projects now in operation have largely been developed by careful planning and utilization of all available resources, Federal, State, and local, public and private. They are wonderful examples of community participation in planning and development of programs for health. However, the neglect of generations, cultural barriers, and the unusual problems found among the migrants cannot be overcome in a few short years. These projects are just now beginning to pay off on the investment. The bill recognizes the fact that special programs for agricultural migrants must be continued through the project mechanism if these people are not to be lost in the shuffle as they have been in the past. I, therefore, urge immediate passage of this bill as recommended by the Committee on Interstate and Foreign Commerce.

The SPEAKER pro tempore (Mr. HOLIFIELD). The question is, on the motion of the gentleman from West Virginia that the House suspend the rules and pass the bill H.R. 14733.

The question was taken; and (two-thirds having voted in favor thereof) the rules were suspended and the bill was passed.

A motion to reconsider was laid on the table.

AUTHORIZING EL PASO AND HUDSPETH COUNTIES, TEX., TO BE PLACED IN THE MOUNTAIN STANDARD TIME ZONE

Mr. STAGGERS. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 14289) to amend the act of March 4, 1921, to place the counties of El Paso and Hudspeth, Tex., in the mountain standard time zone, as amended.

The Clerk read as follows:

H.R. 14289

Be it enacted by the Senate and House of Representatives of the United States of

MONDALE AMENDMENT NO. 402 TO S.2660 - MIGRANT HEALTH ACT

AMENDMENT OF MIGRANT HEALTH ACT TO INSURE MIGRANT PARTICIPATION IN PROGRAM DEVELOPMENT AND IMPLEMENTATION—AMENDMENT

AMENDMENT NO. 4021

Mr. MONDALE. Mr. President, I submit an amendment to S. 2660, a bill to extend and otherwise amend certain expiring provisions of the Public Health Service Act for migrant health services, that would provide for participation of the migrant agricultural worker in program development and implementation.

I am today proposing that section 310 of the Public Health Service Act, which provides money for migratory farmworkers' health care, be amended by adding language that will guarantee participation by the target population in the development and implementation of migrant health programs.

The Migrant Health Act was passed in 1962 with the avowed purpose of providing health care for migrant farmworkers. Before passage of the act, adequate health care was the exception rather than the rule for migrant families. Migrant farmworker families were excluded from traditional health services taken for granted by all the rest of society.

Now, through 116 project grants in 36 States, physicians and hospitals are involved in upgrading the health of farmworkers. The present appropriation of $8 million limits provision of service to only about one-third of the target population, and in many instances, even those services are inadequate or incomplete because of the shortage of funds.

Although the act is improving health care services for migrants, recent hearings in Washington and in the Rio Grande Valley of Texas on the extension of the act, point up the need to involve the consumer population in project development and implementation.

Too often Federal funds are not being used to their fullest advantage. A lack of knowledge on the part of migrants about available facilities and program components still prevails. Many programs lack an adequate outreach component. Too often programs do not take into account the total poverty of migrant families, so that health care is not matched with services to meet related needs of food, shelter, clothing, and other family needs. Special effort and innovation in organizing and delivering services to make them more accessible for the use of geographically and socially isolated migrants is often lacking. Some programs have not explored the possibility of developing new sources of personnel to supplement available professional personnel, such as aides drawn from among migrant families.

Some programs are in the hands of local, county, or State health departments that are insensitive to the needs of migrants or operate heedless of the dignity of the individual. Many local public health programs are already starved for funds, and thus use Migrant Health Act funds to operate their regular programs. Programs are often entwined with legal and policy exclusions from certain local services. Language problems often cause confusion in the delivery of needed services, and staff members are often not bilingual in areas where Spanish is the prevailing tongue. In other instances, health care was not related to the needs of the individual or the family. Experts have documented the fact that greater attention to preventive medicine might obviate the high costs of curing advanced stages of disease.

I am convinced that insufficient health care for the rural poor and the migrant will remain the rule, rather than the exception, until we tap the vast wisdom, understanding, loyalty, and pride of the poor. It is the poor themselves who know most about the details and the solution to their predicament.

My amendment represents a modest, inexpensive device for guaranteeing that those who are excluded from health care be permited to participate in the development and implementation of programs that are intended to improve their health.

My amendment simply requires that before grants are authorized, the Secretary must be satisfied that persons broadly representative of all elements of the population to be served have participated in the development, and will participate in the implementation, of such programs.

The purpose is abundantly clear. It is to have the input of the poor in the implementation and delivery of health care so that the Government and the people get the most for their dollar.

I ask unanimous consent that this amendment be printed in the RECORD at the close of my remarks.

The ACTING PRESIDENT pro tempore. The amendment will be received and printed, and will be appropriately referred; and, without objection, the amendment will be printed in the RECORD.

The amendment (No. 402) was referred to the Committee on Labor and Public Welfare, as follows:

AMENDMENT No. 402

At the end of the bill insert a new sentence as follows:

"SEC. 2. Section 310 of the Public Health Service Act is further amended by adding immediately after the final sentence thereof the following new sentence: For the purposes of assessing and meeting domestic migratory agricultural workers' health needs, developing necessary resources, and involving local citizens in the development and implementation of health care programs authorized by this Section, the Secretary must be satisfied, upon the basis of evidence supplied by each applicant, that persons broadly representative of all elements of the population to be served have been given an opportunity to participate in the development of such programs, and will be given an opportunity to participate in the implementation of such programs."

mittee. Senator MAGNUSON has fought long and hard to improve safety in all modes of transportation. The passage of this bill is another milestone in his distinguished career.

Mr. MAGNUSON. Mr. President, I am gratified that the Senate has at long last approved a comprehensive rail safety bill. Unsafe conditions on some railroads have long been of concern to many Members of the Senate. We have now done something about that concern. I know from personal experience the formidable obstacles that have been placed in the way of congressional approval of rail safety legislation over the years. The chairman of the Subcommittee on Surface Transportation, Senator VANCE HARTKE, made a monumental effort to obtain approval of this vital legislation. He deserves the gratitude of the entire Nation for what is truly an outstanding achievement. Approval of this bill has truly been a bipartisan effort, however. The ranking minority member of the subcommittee, Senator PROUTY as well as other Members from both sides of the aisle have worked long and hard on this legislation.

EXTENSION OF PROVISIONS OF THE PUBLIC HEALTH SERVICE ACT

Mr. BYRD of West Virginia. Mr. President, I ask unanimous consent that the Senate proceed to the consideration of Calendar No. 613.

The PRESIDING OFFICER. The bill will be stated.

The BILL CLERK. A bill (S. 2660) to extend and otherwise amend certain expiring provisions of the Public Health Service Act for Migrant Health Services.

The PRESIDING OFFICER. Is there objection to the request of the Senator from West Virginia?

There being no objection, the Senate proceeded to consider the bill which had been reported from the Committee on Labor and Public Welfare with amendments on page 2, line 2, after "1972", insert "and"; in line 3, after "30", strike out "1973, $35,000,000 for the fiscal year ending June 30, 1974, and $10,000,000 for the fiscal year ending June 30, 1975" and insert "1973"; and, after line 5, insert a new section, as follows:

SEC. 2. Section 310 of the Public Health Service Act is further amended by adding immediately after the final sentence thereof the following new sentence: "For the purposes of assessing and meeting domestic migratory agricultural workers' health needs, developing necessary resources, and involving local citizens in the development and implementation of health care programs authorized by this section, the Secretary must be satisfied, upon the basis of evidence supplied by each applicant, that persons broadly representative of all elements of the population to be served and others in the community knowledgeable about such needs have been given an opportunity to participate in the development of such programs, and will be given an opportunity to participate in the implementation of such programs."

So as to make the bill read:

S. 2660

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 "$9,000,000 each for the fiscal year ending June 30, 1968, and the next fiscal year, and $15,000,000 for the fiscal year ending June 30, 1970", and inserting in lieu thereof "$15,000,000 for the fiscal year ending June 30, 1970, $20,000,000 for the fiscal year ending June 30, 1971, $25,000,000 for the fiscal year ending June 30, 1972, and $30,000,000 for the fiscal year ending June 30, 1973".

SEC. 2. Section 310 of the Public Health Sevice Act is further amended by adding immediately after the final sentence thereof the following new sentence: "For the purposes of assessing and meeting domestic migratory agricultural workers' health needs, developing necessary resources, and involving local citizens in the development and implementation of health care programs authorized by this section, the Secretary must be satisfied, upon the basis of evidence supplied by each applicant, that persons broadly representative of all elements of the population to be served and others in the community knowledgeable about such needs have been given an opportunity to participate in the development of such programs, and will be given an oportunity to participate in the implemention of such programs."

The PRESIDING OFFICER. The question is on agreeing to the amendments.

The amendments were agreed to.

Mr. BYRD of West Virginia. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. BYRD of West Virginia. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. YARBOROUGH. Mr. President, I ask for third reading of S. 2660.

The bill was ordered to be engrossed and to be read a third time.

The bill was read the third time.

Mr. YARBOROUGH. Mr. President, I ask unanimous consent that the Committee on Labor and Public Welfare be discharged from further consideration of H.R. 14733 and that the Senate proceed to the immediate consideration of H.R. 14733.

The PRESIDING OFFICER. Without objection, it is so ordered. The bill will be stated by title.

The LEGISLATIVE CLERK. A bill (H.R. 14733) to amend the Public Health Service Act to extend the program of assistance for health services for domestic migrant agricultural workers and for other purposes.

The PRESIDING OFFICER. Is there objection to the present consideration of the bill?

There being no objection, the Senate proceeded to consider the bill.

Mr. YARBOROUGH. Mr. President, I am indeed gratified to support the passage of this bill to extend and improve health services for domestic migratory farmworkers, which I introduced earlier this year.

The need for increased funds for migrant health services is graphically illustrated by comparing statistics that reveal the per capita expenditures of $12 for health care for migrants, compared with the per capita expenditures of well over $200 for health care for the Nation as a whole. Migrants have been shown to have an incidence of tuberculosis 17 times greater, and infestations with worms 18 times greater, than is seen among patients in private physicians' offices.

Notwithstanding this great need, Federal funds for the years 1967 through 1969 for migrant health services totaled less than $25 million for all 3 years. My bill, S. 2660, authorizes Federal funding for the years 1971 through 1973, which total $75 million or more than triple the funds that were appropriated for 1967 through 1969. The need is great—we must try to meet it.

The bill also strengthens congressional support for the involvement of migrants in the development and implementation of health care programs for their benefit. The Secretary must be satisfied by the project applicant that persons broadly representative of all elements of the population to be served will be given an opportunity to participate in the development and implementation of programs to improve migrant health services. Thus the migrants themselves must be involved in the health projects.

The Committee on Labor and Public Welfare agreed unanimously that the migrant health program should be "a permanently and separately identifiable program." The action taken by the Public Health Service to destroy the separate identity and operation of the migrant health program must be reversed. The staff should be reinstituted as a core unit.

We are on the road to overcoming generations of neglect. We should continue on this road. S. 2660 provides an opportunity. As chairman of the Committee on Labor and Public Welfare, I urge its immediate passage.

Mr. President, I move that all after the enacting clause be stricken and that the text of S. 2660 as amended be inserted in lieu of the text of H.R. 14733.

The PRESIDING OFFICER. The question is on agreeing to the motion of the Senator from Texas.

The motion was agreed to.

The PRESIDING OFFICER. The question now is on the engrossment of the amendment and the third reading of H.R. 14733.

The amendment was ordered to be engrossed and the bill (H.R. 14733) to be read a third time.

The bill was read the third time, and passed.

Mr. YARBOROUGH. Mr. President, I ask unanimous consent that S. 2660 be indefinitely postponed.

The PRESIDING OFFICER. Without objection, it is so ordered.

The title was amended so as to read: "To extend and otherwise amend certain expiring provisions of the Public Health Service Act for migrant health services."

SENATOR ELLENDER ADDRESSES THE NATIONAL AERIAL APPLICATORS ASSOCIATION CONFERENCE

Mr. ELLENDER. Mr. President, I ask unanimous consent that an address I delivered before the National Aerial Applicators Association Conference in New Orleans on December 9, 1969, be printed at this point in the RECORD.

what has happened to the great drive to modernize congressional rules and machinery. And, of course, I find it more and more necessary to express my regret that my friends on the other side of the aisle who control this House have refused to let us act on congressional reform.

I certainly trust that we will not have to provide the same answer when we face our constituents later this year. Congressional reform is not of course a partisan issue. We all seem to be for it—so let us stop talking and act on a bill.

HOW TO STOP SKY MURDERS

(Mr. MORSE asked and was given permission to address the House for 1 minute and to revise and extend his remarks and include extraneous matter.)

Mr. MORSE. Mr. Speaker, the kind of sabotage that resulted most recently in the loss of 47 innocent lives onboard a Swissair plane destined for Israel, and endangered those on an Austrian plane transporting mail to Israel, is an outrage and a tragedy, the horror of which needs no embellishment. What it portends for the continuing conflict in the Middle East, and for the future of world aviation, however, cannot be understated.

It is the responsibility of the international community to take steps to insure that such tragedies do not happen again. This involves more than improving in-flight security; it calls for a concerted and firm agreement, making it clear in the most definite terms that all governments of the Middle East will be assigned clear responsibility for controlling the activities of individuals and organizations operating in or from their territory.

Members of the Arab guerrilla groups which have undertaken such terrorist activity in the past and are suspected of instigating the latest attacks, can no longer remain unclaimed by the governments which have tolerated their actions and issued passports for their travel abroad. The world cannot allow them to remain aloof from law and justice.

Neither should Israel be penalized for being so victimized. The security of international airlines must be reassessed and improved, but services must be fully reinstated to Israel. To do otherwise would be to place a premium on such terror tactics. It would, as the following editorial in the February 24 Boston Globe states, "contribute to the toleration of murder and the disruption of international travel" by the international community:

HOW TO STOP SKY MURDERS

The Arab guerrilla sabotage which on Feb. 21 destroyed a Swiss airliner flying to Israel with the loss of 47 lives, and on the same day almost destroyed an Austrian plane carrying mail to Israel, confronts the civilized world with a challenge that must be met head-on, and immediately and decisively.

Nothing could be less convincing than the denial of responsibility issued by an Arab guerrilla organization, in the light of both its earlier claim that it had engineered the disaster, and a record of similar guerrilla terrorist attacks that date back to July 23, 1968, when an El Al Airline plane was hijacked to Algiers after taking off from Rome.

Since then, and until last weekend's two atrocities, there had been two other attacks on El Al planes at airports in Athens and Zurich with the loss of three lives, two more attacks by grenade on El Al offices in Brussels and Athens with a 2-year-old Greek boy killed, and still another attack on El Al passengers at the Munich airport only last Feb. 10 in which an Israeli was killed and 11 persons were injured.

Almost as difficult to understand as these shocking acts of Arab guerrilla sabotage has been the reaction of most of Europe's major airlines in canceling freight and mail deliveries to Israel. To be sure, the ban was described as temporary. But it was precisely what the Arab terrorists have wanted to achieve by their hideous acts, and can only encourage their repetition once air deliveries have been resumed.

Also contributing to the toleration of murder and the disruption of international travel was last week's indefinite postponement by a criminal court in Athens of the murder trial of two Arabs who attacked an Israeli airliner there almost 14 months ago.

The answer to these terrorist attacks does not lie in postponing punishment for the culprits or in cutting off air deliveries to Israel. Rather it lies in the sternest of reaction from all civilized countries.

They must apply sanctions against those Arab countries which encourage and finance the terrorists. Instead of cutting off flights to Israel, the international airlines should act jointly to boycott these Arab states which are the source of the international murder and piracy in the air and on the ground.

Nothing less than such sanctions can stop these atrocities.

(Mr. MORSE asked and was given permission to extend his remarks at this point in the RECORD and to include extraneous matter.)

[Mr. MORSE'S remarks will appear hereafter in the Extensions of Remarks.]

OIL IMPORT POLICY

(Mr. BUSH asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. BUSH. Mr. Speaker, much has been said on the matter of policy this Nation should follow with respect to its oil import program. No study of our oil import policy is complete without a realization of the effects the policy has on our national defense. This is particularly true now—when instability in the Middle East severely threatens sources of our petroleum imports from that region of the world.

An oil import policy based on a tariff system, which would allow this Nation to become dependent upon oil imports from other countries, and break the price of American crude, could halt American oil exploration. In turn, new natural gas deposit discoveries, almost all of which are found incidental to oil exploration, would be halted. With indications of a developing natural gas shortage in the United States, a reduction in American oil exploration would be detrimental in finding new, necessary sources of natural gas deposits.

With this in mind, I have introduced a bill establishing 12.2 percent statutory quotas on imports of petroleum and petroleum products, and to impose reciprocal duties on petroleum and petroleum products imported from foreign countries which impose duties on petroleum and petroleum products produced in the United States. It is an extension of H.R. 10706 which I introduced in June 1967.

In view of the President's recent decision to give further consideration to the national security aspects of this issue, perhaps this legislation will provide a vehicle for rational public discussion.

CONFERENCE REPORT ON H.R. 14733, HEALTH SERVICES FOR DOMESTIC AGRICULTURAL MIGRANTS

Mr. STAGGERS submitted the following conference report and statement on the bill (H.R. 14733) to amend the Public Health Service Act to extend the program of assistance for health services for domestic migrant agricultural workers and for other purposes:

CONFERENCE REPORT (H. REPT. No. 91-853)

The committee of conference on the disagreeing votes of the two Houses on the amendments of the Senate to the bill (H.R. 14733) to amend the Public Health Service Act to extend the program of assistance for health services for domestic migrant agricultural workers and for other purposes, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the House recede from its disagreement to the amendment of the Senate to the text of the bill and agree to the same with an amendment as follows: In lieu of the matter proposed to be inserted by the Senate amendment insert the following:

That section 310 of the Public Health Service Act (42 U.S.C. 242h) is amended—

(1) by striking out "and" after "next fiscal year,", and by inserting after "June 30, 1970," the following: "$20,000,000 for the fiscal year ending June 30, 1971, $25,000,000 for the fiscal year ending June 30, 1972, and $30,000,000 for the fiscal year ending June 30, 1973,".

(2) by adding at the end thereof the following new sentence: "The Secretary may also use funds appropriated under this section to provide health services to persons (and their families) who perform seasonal agricultural services similar to the services performed by domestic agricultural migratory workers if the Secretary finds that the provision of health services under this sentence will contribute to the improvement of the health conditions of such migratory workers and their families."

(3) by adding immediately after the sentence added by paragraph (2) the following new sentence: "For the purposes of assessing and meeting domestic migratory agricultural workers' health needs, developing necessary resources, and involving local citizens in the development and implementation of health care programs authorized by this section, the Secretary must be satisfied, upon the basis of evidence supplied by each applicant, that persons broadly representative of all elements of the population to be served and others in the community knowledgeable about such needs have been given an opportunity to participate in the development of such programs, and will be given an opportunity to participate in the implementation of such programs."

(4) by striking out "to improve health services for and the health conditions of" in clause (1)(B) and inserting in lieu thereof "to improve and provide a continuity of health services for and to improve the health conditions of".

(5) by inserting "(including allied health professions personnel)" after "training persons" each place it appears in clause (1).

(6)(A) by striking out "Surgeon General" and inserting in lieu thereof "Secretary", and

(B) by inserting at the beginning of an

section the following heading: "Health Services for Domestic Agricultural Migrants".

And the Senate agree to the same.

That the Senate recede from its amendment to the title.

HARLEY O. STAGGERS,
JOHN JARMAN,
PAUL G. ROGERS,
DAVID E. SATTERFIELD III,
WILLIAM L. SPRINGER,
ANCHER NELSEN,
TIM LEE CARTER,
Managers on the Part of the House.

RALPH YARBOROUGH,
HARRISON A. WILLIAMS, Jr.,
EDWARD M. KENNEDY,
GAYLORD NELSON,
THOMAS F. EAGLETON,
ALAN CRANSTON,
HAROLD E. HUGHES,
PETER H. DOMINICK,
JACOB K. JAVITS,
GEORGE MURPHY,
WINSTON L. PROUTY,
WILLIAM B. SAXBE,
Managers on the Part of the Senate.

STATEMENT

The managers on the part of the House at the conference on the disagreeing votes of the two Houses on the amendments of the Senate to the bill (H.R. 14733) to amend the Public Health Service Act to extend the program of assistance for health services for domestic migrant agricultural workers and for other purposes, submit the following statement in explanation of the effect of the action agreed upon by the conferees and recommended in the accompanying conference report:

The Senate amendments struck out all of the House bill after the enacting clause and inserted a substitute text and provided a new title for the House bill.

With respect to the amendment of the Senate to the text of the House bill, the House recedes from its disagreement to the amendment of the Senate, with an amendment which is a substitute for both the House bill and the Senate amendment. The differences between the Senate amendment and the substitute agreed to in conference are noted below except for minor technical and clarifying changes made necessary by reason of the conference agreement.

AUTHORIZATION OF APPROPRIATIONS

The House bill amended section 310 of the Public Health Service Act to extend for 3 fiscal years (fiscal year 1971 through fiscal year 1973) the authorization of appropriations for programs of assistance for health services for domestic migrant agricultural workers. The following amounts were authorized: $20 million for fiscal year 1971, $25 million for fiscal year 1972, and $30 million for fiscal year 1973.

The Senate amendment and the conference substitute are identical to this amendment made by the House bill.

SERVICES FOR SEASONAL AGRICULTURAL WORKERS

In another amendment to section 310, the House bill authorized the Secretary of Health, Education, and Welfare to use funds appropriated under that section to provide health services to seasonal agricultural workers (and their families) when he found that the provision of such services would contribute to the improvement of the health conditions of the domestic migrant agricultural workers and their families who may presently receive health services under that section.

The Senate amendment contained no similar provision.

The conference substitute is the same as the House bill in this regard, and provides that project grants may be made to provide health services for certain seasonal agricultural employees. This provision is intended to be restricted in its applicability to projects in areas where migratory workers reside, and is to be limited to projects which will improve the health conditions of migratory workers themselves.

COMMUNITY PARTICIPATION IN DEVELOPMENT AND IMPLEMENTATION OF PROGRAMS

The Senate amendment contained a provision not in the House bill requiring applicants for assistance under section 310 to give the Secretary satisfactory assurances that persons broadly representative of all elements of the population to be served and others in the community knowledgeable about such needs have been given an opportunity to participate in the development of programs for domestic migratory agricultural workers' health needs and that such persons will be given an opportunity to participate in the implementation of such programs.

The conference substitute is the same as the Senate bill in this regard.

It is the intent of the conferees with respect to citizen participation in development and implementation of these programs that such participation extend to development of new, or modification of existing, programs, but does not extend to the actual administration of the programs themselves.

PROGRAM ADMINISTRATION

Two years ago, when this act was last extended, the conferees agreed that it ". . . should also be considered as a permanent and separately identifiable program. . . ." Because residency requirements still exclude migrants from many State health programs and because there continues to be a lack of willingness or financial ability to include migrants in State and local programs for the general population, we wish to restate this position and express concern that the 1968 Public Health Service reorganization may have seriously compromised the separately identifiable status of the program, contrary to the intent expressed in last extending the act.

HARLEY O. STAGGERS,
JOHN JARMAN,
PAUL G. ROGERS,
DAVID E. SATTERFIELD III,
WILLIAM L. SPRINGER,
ANCHER NELSEN,
TIM LEE CARTER,
Managers on the Part of the House.

CONFERENCE REPORT ON H.R. 11702, MEDICAL LIBRARY ASSISTANCE EXTENSION ACT OF 1969

Mr. STAGGERS submitted the following conference report and statement on the bill (H.R. 11702) to amend the Public Health Service Act to improve and extend the provisions relating to assistance to medical libraries and related instrumentalities, and for other purposes:

CONFERENCE REPORT (H. REPT. No. 91-834)

The committee of conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 11702) to amend the Public Health Service Act to improve and extend the provisions relating to assistance to medical libraries and related instrumentalities, and for other purposes, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the House recede from its disagreement to the amendment of the Senate and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the Senate amendment insert the following:

SHORT TITLE

SECTION 1. This Act may be cited as the "Medical Library Assistance Extension Act of 1970".

THREE-YEAR EXTENSION OF EXISTING PROGRAMS

SEC. 2. (a) Subsection (i) of section 393 of the Public Health Service Act (42 U.S.C. 280b-3(i)) (relating to assistance for construction of medical library facilities) is amended to read as follows:

"(i) For the purposes of carrying out the provisions of this section, there are authorized to be appropriated $11,000,000 for the fiscal year ending June 30, 1971, $12,000,000 for the fiscal year ending June 30, 1972, and $13,000,000 for the fiscal year ending June 30, 1973."

(b) The first sentence of subsection (a) of section 394 of such Act (42 U.S.C. 280b-4(a)) (relating to grants for training in medical library sciences) is amended to read as follows: "In order to enable the Secretary to carry out the purposes of section 390(b)(2), there are authorized to be appropriated $1,500,000 for the fiscal year ending June 30, 1971, $1,750,000 for the fiscal year ending June 30, 1972, and $2,000,000 for the fiscal year ending June 30, 1973."

(c) Section 395 of such Act (42 U.S.C. 280b-5) (relating to assistance for compilations or writings concerning advances in sciences related to health) is amended by striking out "June 30, 1970" and inserting in lieu thereof "June 30, 1973".

(d) Subsection (a) of section 396 of such Act (42 U.S.C. 280b-6(a)) (relating to research and development in medical library science and related fields) is amended by striking out "June 30, 1970" and inserting in lieu thereof "June 30, 1973".

(e) Subsection (a) of section 397 of such Act (42 U.S.C. 280b-7(a)) (relating to assistance to improve or expand basic medical library resources) is amended to read as follows:

"(a) In order to enable the Secretary to carry out the purposes of section 390(b)(5), there are authorized to be appropriated $3,500,000 for the fiscal year ending June 30, 1971, $4,000,000 for the fiscal year ending June 30, 1972, and $4,500,000 for the fiscal year ending June 30, 1973."

(f) The first sentence of subsection (a) of section 398 of such Act (42 U.S.C. 280b-8(a)) (relating to grants for establishment of regional medical libraries) is amended to read as follows: "In order to enable the Secretary to carry out the purposes of section 390(b)(6), there are authorized to be appropriated $3,000,000 for the fiscal year ending June 30, 1971, $3,250,000 for the fiscal year ending June 30, 1972, and $3,500,000 for the fiscal year ending June 30, 1973."

(g) Subsection (a) of section 399 of such Act (42 U.S.C. 280b-9(a)) (relating to assistance for biomedical scientific publications) is amended by striking out "June 30, 1970" and inserting in lieu thereof "June 30, 1973".

GRANTS FOR CONSTRUCTION OF MEDICAL LIBRARY FACILITIES

SEC. 3. Section 393 of the Public Health Service Act (42 U.S.C. 280b-3) is amended—

(1) by amending clause (B) of subsection (b)(1) to read as follows: "(B) sufficient funds will be available to meet the non-Federal share of the cost of constructing the facility, and";

(2) by striking out subsection (c) and redesignating subsections (d), (e), (f), (g), (h) and (i) as subsections (c), (d), (e), (f), (g), and (h), respectively; and

(3) by striking out in subsection (c) (as so redesignated by this section) ", and shall give priority to applications for construction of facilities for which the need is greatest".

GRANTS FOR SPECIAL SCIENTIFIC PROJECTS

SEC. 4. (a) Section 395 of the Public Health Service Act (42 U.S.C. 280b-5) is amended—

(1) by striking out in the second sentence "for the establishment of special fellowships to be awarded to physicians and other practitioners in the sciences related to health and scientists" and inserting in lieu thereof the

EFFECTIVE DATE

SEC. 12. (a) Except as provided in subsection (b) the amendments made by this Act shall apply with respect to appropriations for fiscal years ending after June 30, 1970.

(b) The amendments made by sections 10 (d) and 11 shall take effect on the date of the enactment of this Act.

And the Senate agree to the same.

RALPH W. YARBOROUGH,
HARRISON WILLIAMS,
EDWARD KENNEDY,
GAYLORD NELSON,
THOMAS F. EAGLETON,
ALAN CRANSTON,
HAROLD E. HUGHES,
PETER H. DOMINICK,
JACOB K. JAVITS,
GEORGE L. MURPHY,
WINSTON PROUTY,
WM. B. SAXBE,
Managers on the Part of the Senate.

HARLEY O. STAGGERS,
JOHN JARMAN,
PAUL G. ROGERS,
WILLIAM L. SPRINGER,
TIM LEE CARTER,
Managers on the Part of the House.

The PRESIDING OFFICER. Is there objection to the present consideration of the report?

There being no objection, the Senate proceeded to consider the report.

Mr. YARBOROUGH. Mr. President, the conferees have agreed to an extension of the Medical Library Assistance Act.

The bill, as agreed to in conference, would extend for 3 years the current program to provide financial assistance for the construction of health library facilities; to support training of health librarians and other information specialists; to expand and improve health library services through the provision of grants for library resources; to support projects of research and development in the field of health communications, and related special scientific projects; to support the development of a national system of regional medical libraries; and to support selected bio-medical scientific publications projects.

An important amendment would permit the Secretary to transfer funds under specified limitations within the authorization permitted by this act. This will assure that the congressional responsibility for program administration is retained, while permitting a more flexible administration of the program.

For the construction assistance program, the bill would increase the authorization ceiling from $10 to $11 million in fiscal year 1971, $12 million in fiscal year 1972, and $13 million in fiscal year 1973 for new health library construction and for projects to renovate and expand existing health library space.

The conferees agreed to include the provision of the House bill eliminating language in section 393(d)—redesignated as (c) by this bill—providing priority to applications for construction of facilities for which the need is greatest. This provision can operate to deprive projects which have matching funds available of their share of Federal matching funds because other projects have greater priority, although the other projects may not be in a position to be initiated. It is the intent of the conferees, however, that where projects have available funding to match Federal grants, priority shall be given to those projects for which the need is greatest, notwithstanding the deletion of this language.

For the program to train health librarians and other information specialists for administrative, service, and research positions, the bill would increase the authorization for the support of training grants and fellowships from $1 million to $1.5 million in fiscal year 1971, $1.75 million in fiscal year 1972, and $2 million in fiscal year 1973.

The conferees agreed to increase the authorization for funding for the library resource grants program from $3 million to $3.5 million for fiscal year 1971, $4 million for fiscal year 1972, and $4.5 million for fiscal year 1973. These funds will be used to improve the basic resources of health libraries.

For the program of grant assistance for the development of regional medical libraries, the conferees agreed to increase the authorization for funding from $2.5 million in fiscal year 1970 to $3 million in fiscal year 1971, $3.25 million in fiscal year 1972, and $3.5 million in fiscal year 1973.

Section 399 of the Public Health Service Act which authorizes financial support for biomedical scientific publications is amended to broaden the eligibility for assistance under that section. Currently, assistance may be provided only to institutions of higher education and scientists. The conferees agreed that assistance may be provided to scientists and any nonprofit private institution.

The conferees also agreed to permit the Secretary to make exceptions to the 3-year limit on assistance for any single publication if he determines extension of support would advance the purposes of the program.

The Medical Library Assistance Amendments will not resolve all the needs and problems in health communications. They will, however, provide assistance where needed and stimulate the formulation and adaptation of new ideas and concepts for making health information available.

The PRESIDING OFFICER. The question is on agreeing to the conference report.

The report was agreed to.

AMENDMENT OF PUBLIC HEALTH SERVICE ACT TO EXTEND THE PROGRAM TO CERTAIN MIGRANT AGRICULTURAL WORKERS—CONFERENCE REPORT

Mr. YARBOROUGH. Mr. President, I submit a report of the committee of conference on the disagreeing votes of the two Houses on the amendments of the Senate to the bill (H.R. 14733) to amend the Public Health Service Act to extend the program of assistance for health services for domestic migrant agricultural workers, and for other purposes. I ask unanimous consent for the present consideration of the report.

The PRESIDING OFFICER. The report will be read for the information of the Senate.

The assistant legislative clerk read the report, as follows:

CONFERENCE REPORT (H. REPT. No. 91-853)

The committee of conference on the disagreeing votes of the two Houses on the amendments of the Senate to the bill (H.R. 14733) to amend the Public Health Service Act to extend the program of assistance for health services for domestic migrant agricultural workers and for other purposes, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the House recede from it disagreement to the amendment of the Senate to the text of the bill and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the Senate amendment insert the following:

That section 310 of the Public Health Service Act (42 U.S.C. 242h) is amended—

(1) by striking out "and" after "next fiscal year,", and by inserting after "June 30, 1970," the following: "$20,000,000 for the fiscal year ending June 30, 1971, $25,000,000 for the fiscal year ending June 30, 1972, and $30,000,000 for the fiscal year ending June 30, 1973,".

(2) by adding at the end thereof the following new sentence: "The Secretary may also use funds appropriated under this section to provide health services to persons (and their families) who perform seasonal agricultural services similar to the services performed by domestic agricultural migratory workers if the Secretary finds that the provision of health services under this sentence will contribute to the improvement of the health conditions of such migratory workers and their families."

(3) by adding immediately after the sentence added by paragraph (2) the following new sentence: "For the purposes of assessing and meeting domestic migratory agricultural workers' health needs, developing necessary resources, and involving local citizens in the development and implementation of health care programs authorized by this section, the Secretary must be satisfied, upon the basis of evidence supplied by each applicant, that persons broadly representative of all elements of the population to be served and others in the community knowledgeable about such needs have been given an opportunity to participate in the development of such programs, and will be given an opportunity to participate in the implementation of such programs."

(4) by striking out "to improve health services for and the health conditions of" in clause (1)(ii) and inserting in lieu thereof "to improve and provide a continuity in health services for and to improve the health conditions of".

(5) by inserting "(including allied health professions personnel)" after "training persons" each place it appears in clause (1).

(6) (A) by striking out "Surgeon General" and inserting in lieu thereof "Secretary", and (B) by inserting at the beginning of such section the following heading: "Health Services for Domestic Agricultural Migrants".

And the Senate agree to the same.

That the Senate recede from its amendment to the title.

RALPH W. YARBOROUGH,
HARRISON WILLIAMS,
EDWARD KENNEDY,
GAYLORD NELSON,
THOMAS F. EAGLETON,
ALAN CRANSTON,
HAROLD E. HUGHES,
PETER H. DOMINICK,
JACOB K. JAVITS,
GEORGE L. MURPHY,
WINSTON PROUTY,
WM. B. SAXBE,
Managers on the Part of the Senate.

HARLEY O. STAGGERS,
JOHN JARMAN,
PAUL G. ROGERS,
DAVID SATTERFIELD,
WILLIAM L. SPRINGER,
ANCHER NELSEN,
TIM LEE CARTER,
Managers on the Part of the House.

The PRESIDING OFFICER. Is there objection to the present consideration of the report?

There being no objection, the Senate proceeded to consider the report.

Mr. YARBOROUGH. Mr. President, the conferees have agreed to an extension of the Migrant Health Act, H.R. 14733. For the Nation as a whole, 900 counties furnish seasonal homes, or work areas—or both—for an estimated 1,000,000 migrant farmworkers and their dependents. About one-fifth of the Nation's total migrants live seasonally in 117 counties of Texas, and go out from Texas, their homeland, to work the fields in other States.

For a variety of reasons, migrant farmworkers and their families are the group most likely to be bypassed by national health gains. They are poor, live in inadequate housing, are often geographically isolated, belong to various minority groups—chiefly Mexican-American and Negro—and frequently lack knowledge of good health practices and of community health resources.

The "channels" to gain access to health care frighten and confuse them, for they fear the sterile atmosphere of the typical clinic or hospital. Moreover, their constant movement hinders continuity of the scanty services they do receive. Many of their temporary communities look upon them as transients for whom the community feels no responsibility. These communities often lack enough physicians, dentists, and nurses to meet the needs of local residents, let alone the needs of people "just passing through."

The result is a heavy burden of illness and disability. Tuberculosis is 17 times more frequent and infestation with worms 35 times more frequent among migrants than among ordinary patients. Mortality from tuberculosis and other infectious diseases is 2½ times the national average. Mortality from accidents is nearly 3 times the national average. Infant mortality is at the national rate of 20 years ago. As late as 1966, in two Texas border counties—Cameron and Hidalgo—which are home for many thousands of Mexican-American migrants—29 percent of the births occurred outside of hospitals, compared with 2 percent for the Nation as a whole.

At the fiscal 1969 appropriation level of $8 million, the amount available nationally per migrant is $8. Even when contributions from other than migrant health sources are added, the total average health expenditure per migrant is little more than $12. This can be compared with the national average per capita health expenditure of over $250.

Because of these great needs, the conferees have agreed to legislation which would extend the Migrant Health Act for 3 years and increase the appropriation authorization from $15 million in 1970 to $30 million in 1973.

The House bill provided that the Secretary may use funds under the Migrant Health Act to provide health services to nonmigrants the same as to migrants if the Secretary of Health, Education, and Welfare determines that the expenditure would improve the health of migrants. The managers on the part of the Senate have agreed to this amendment recognizing that, in some circumstances, it is difficult to achieve the purpose of the act without improving health conditions for all persons when living and working together. Sanitation programs, water supply improvement, and rat control efforts are examples of this fact. We agreed that in using funds appropriated to carry out the purposes of this provision, the Secretary shall be reasonably assured that this will not result in a reduction of effort or unduly discourage an expansion of the effort by any State, county, or municipal body to provide health care services to migrants. We wish to emphasize that in providing services under the Migrant Health Act, under all circumstances, all other resources should be exhausted and responsibilities assumed for nonmigrants should be transferred to appropriate local bodies whenever possible.

The Senate amendment provided that the Secretary must be satisfied that persons representative of the population served and others in the community knowledgeable of migrant health needs have been given an opportunity to participate in the development and implementation of each program. The House bill contained no provision on this subject. The managers on the part of the House have agreed to this amendment.

Two years ago, when this act was last extended, the conferees agreed that it "should also be considered as a permanent and separately identifiable program." Because residency requirements still exclude migrants from many State health programs and because there continues to be a lack of willingness or financial ability to include migrants in State and local programs for the general population, we wish to restate this position and express concern that the 1968 Public Health Service reorganization may have seriously compromised the separately identifiable status of the program, contrary to the intent expressed in last extending the act.

The extension, the increases in funds, and the improvements in the act agreed to by both Houses are absolutely necessary if we are ever to meet such great needs.

The PRESIDING OFFICER. The question is on agreeing to the conference report.

The report was agreed to.

THE CARSWELL AFFAIR

Mr. BROOKE. Mr. President, the Senate will soon be called to act upon the nomination of Judge G. Harrold Carswell to be Associate Justice of the Supreme Court. The Senate bears no less responsibility than the President in the process of selecting members of the Supreme Court; for both the Senate and the President are charged by the Constitution to insure the integrity and high quality of the third branch of Government. Thus, the question of confirmation in such cases is of unique importance. I have withheld comment on the nomination until the completion of my study of the hearing record and other relevant materials, including a number of Judge Carswell's written opinions as a district judge. I have given the pending nomination as careful and deliberate an evaluation as I could.

I will vote against confirmation of Judge Carswell.

Mr. President, I had earnestly hoped for a nominee who would unite this body and this Nation in approval of his qualifications. I would have been pleased to conclude that the criticism of this nomination was unfounded and that Judge Carswell's performance as a lawyer and jurist should be rewarded by appointment to the highest court. In some areas of the law I believe that Judge Carswell shows competence, though not the clear distinction which the country rightly demands in a Justice of the Supreme Court. But competent service on a lower court may well be a prelude to growth on the highest tribunal. If that standard alone governed, Judge Carswell might easily be entitled to the benefit of the doubt.

Particularly in this instance, however, that is not the only relevant test. It could not be sufficient for a man who began his public career with a profound and far-reaching commitment to an anticonstitutional doctrine, a denial of the very pillar of our legal system, that all citizens are equal before the law. G. Harrold Carswell's 1948 pledge of external allegiance to white supremacy, even when read in the context of a heated political campaign, is irreconcilable with the American system of justice. It is important to recognize that his professions in that year are not only alien to the law as it stands today; they were clearly hostile to the constitutional standard which had prevailed at least since Plessy against Ferguson before the turn of the century.

I doubt seriously that, had the nominee's expressed views of 1948 been known to the President, Judge Carswell's name would have been sent to the Senate. Had they emerged prior to the nomination, a more careful analysis of the prospective nominee's overall record would have been required, and analyzed in that context, it would probably have been found lacking. While such remarks by a young, but mature political candidate may not by themselves be disqualifying, they do pose in stark relief a central question: What subsequent evidence indicates that the individual has abandoned a doctrine clearly offensive to the law and the ideals of this Nation.

I confess that I was eager to discover such evidence. I searched the record for convincing proof that Judge Carswell's later actions revealed a true dedication to the principles of equal rights under law. I searched in vain.

It is, of course, true that the judge has publicly repudiated the 1948 statement and has denied that he is not a racist. His declaration deserves to be considered fairly, but it cannot be allowed to weigh more heavily than his deeds. In examining his private and public record, I find it barren of the kind of affirmative statements and efforts which would suggest that Judge Carswell had in fact rejected his earlier views. On the other hand, that same record includes a number of actions which either confirm or invite suspicion that his anticonstitutional inclinations continued to hold sway. Given such an ex-

sion of these additional programs in this bill limiting, however, both of them to 3 years and reducing somewhat the authorizations included in the version which passed the other body. As a result we are recommending authorizations for the traineeships at $14, $16, and $18 million for the next 3 years, and $14, $15, and $16 million for project grants. Since authorizations were already available for the last two programs for fiscal 1971, the extensions are for a total of 3 years but only two of these are new. This makes all three programs terminate simultaneously which should expedite and make their consideration more logical in the future.

I recommend that the House adopt the conference report.

Mr. STAGGERS. Mr. Speaker, I move the previous question on the conference report.

The previous question was ordered.

The conference report was agreed to.

A motion to reconsider was laid on the table.

CONFERENCE REPORT ON H.R. 14733, HEALTH SERVICES FOR DOMESTIC AGRICULTURAL MIGRANTS

Mr. STAGGERS. Mr. Speaker, I call up the conference report on the bill (H.R. 14733) to amend the Public Health Service Act to extend the program of assistance for health services for domestic migrant agricultural workers and for other purposes, and ask unanimous consent that the statement of the managers on the part of the House be read in lieu of the report.

The Clerk read the title of the bill.

The SPEAKER pro tempore (Mr. ROONEY of New York). Is there objection to the request of the gentleman from West Virginia?

There was no objection.

The Clerk read the statement.

(For conference report and statement, see proceeding of the House of February 25, 1970.)

Mr. STAGGERS. Mr. Speaker, the conference report presently before the House provides a 3-year extension of the existing program under which health services are provided for domestic agricultural migrant workers. Both the House and Senate versions of the legislation contain the same level of funding, so that the report is identical to the bill as it passed the House in this regard. The House bill also provided coverage under project grants for a limited number of seasonal agricultural workers, where providing health services to these persons would improve health conditions of migrants themselves. The conference agreement is identical to the House bill in this regard.

The Senate bill also contains an amendment providing for community participation in the development of programs. The House conferees accepted this Senate amendment, with the understanding that community participation in the development and implementation of these programs would be limited to the development of new, or modification of existing programs, but do not extend to the actual administration of the programs. It is our feeling that the modification should apply to new grants made hereafter, and to renewals of existing grants at the time they are considered for renewal.

The managers on the part of the House were unanimous in their agreement to the report, and we recommend the adoption by the House.

Mr. ROGERS of Florida. Mr. Speaker, will the gentleman yield?

Mr. STAGGERS. I am glad to yield to the gentleman from Florida.

(Mr. ROGERS of Florida asked and was given permission to revise and extend his remarks.)

Mr. ROGERS of Florida. Mr. Speaker, I rise in support of this conference report.

Since this legislation was passed into law in 1962, hundreds of thousands of migrant workers in almost all parts of this Nation have received medical help. Each year of the program has seen additional migrant workers helped.

This year's extension of that legislation, however, is to date the broadest and most effective since its original passage.

For the first time we are enlarging the target area to those persons who work with and whose health conditions also affect the migrants in the fields. We estimate that there are approximately 1 million migrants, but there are at least a million additional seasonal workers and maybe as many as 2 million who do not leave their home base.

Yet these people who work side by side with the migrants have not had the benefit of the program, but they should. The health problems of the farm workers are not limited to traveling workers. Domestic and migrant workers are together in the fields, and we cannot continue to overlook the fact that disease and illness can spread without regard to classification of the worker.

This bill calls for appropriation of $20 million in fiscal 1971, $25 million in fiscal 1972, and $30 million for fiscal 1973. This represents an encouraging increase over this year's $15 million. But based on a million migrant population figure, it allows for an average of only $20 per person for medical care compared to the national average of more than $300 for each man, woman, and child in the nonmigrant population. So it is evident that we can do still more in this area.

For my colleagues who are not completely familiar with the migrant health program, I would like to point out that migrant use of medical care is about one-seventh the national average. Their dental care is about one-twentieth, and their use of hospital care is about one-fourth that of the general population.

The mortality of migrants from TB, influenza, pneumonia, and other infectious diseases is more than twice the national average. These also exist and are similar in the seasonal agricultural workers and their families.

Although there are three main migrant streams, the area covered by these wandering workers is national in scope and indeed is a national problem.

So far, we have estimated that only one-third of the migrant population has been reached by the program. We must do better.

I am encouraged at the work being done in Florida. In the Palm Beach County area there is a peak migrant population of approximately 38,000. The county health officer there has reported that all 38,000 have received some benefits from the Migrant Health Act. In addition, more than 11,000 have received medical assistance, either through aid in clinics or hospitals.

To give an idea of the scope of the program on the national level, it is estimated that 120,000 received medical care last year; 21,000 received dental care and there were 210,000 medical visits and 28,000 dental visits.

In Broward County, approximately 3,000 have received direct medical treatment. Almost 1,000 have received dental treatment, 1,000 have been helped in nursing clinics and 1,400 have participated in the immunization program. During the past year, migrants have registered almost 3,900 visits to clinics and have been treated in hospitals for 1,161 days.

Mr. Speaker, presently there are 116 single or multicounty projects operating with Migrant Health Act assistance in 36 States and Puerto Rico. Yet, there are 900 of the Nation's 3,000 counties that are annually temporary homes to migrants ranging in number from 100 to 40,000.

These 116 projects reach 300 counties, but in the other 600 counties health care is sporadic and often crisis oriented. We have made progress. But we still must do more. We must reach those remaining two-thirds of the target areas.

I think that H.R. 14733 will help us in assuring that the migrant and seasonal farmworkers in this Nation are assured of decent health service. I urge passage of this legislation and commend those who have worked on this very important program.

Mr. GONZALEZ. Mr. Speaker, will the gentleman yield?

Mr. STAGGERS. I shall be happy to yield to the gentleman from Texas.

(Mr. GONZALEZ asked and was given permission to revise and extend his remarks.)

Mr. GONZALEZ. Mr. Speaker, I, too, want to rise in support of this commendable legislation and would like to know if the gentleman from West Virginia will yield for a question?

Mr. STAGGERS. I would be happy to do so.

Mr. GONZALEZ. With respect to the certain types of migratory workers, what exactly does this mean?

Mr. STAGGERS. All migratory workers that come from outside the State or move in interstate commerce.

Mr. GONZALEZ. All migratory workers?

Mr. STAGGERS. Yes, sir.

Mr. GONZALEZ. In the statement accompanying this conference report you refer to the fact—and this can be found on page 3—that this is to be limited to projects which will improve the health conditions of migratory workers themselves?

Mr. STAGGERS. I might explain this—that certain workers in the United States who are employed in a group of

migratory workers from outside, if there is a disease of any kind or epidemic of any kind or certain conditions that necessitate the migratory workers receive health care, then the others could receive help.

Mr. GONZALEZ. One further question: This is not intended to be limited to the permanent residence of the migratory workers?

Mr. STAGGERS. No, it is not.

Mr. GONZALEZ. I thank the gentleman very much and I commend the gentleman for this very worthy legislation.

Mr. PICKLE. Mr. Speaker, will the gentleman yield?

Mr. STAGGERS. I yield to the gentleman from Texas.

(Mr. PICKLE asked and was given permission to revise and extend his remarks.)

Mr. PICKLE. Mr. Speaker, I rise in support of this legislation.

Mr. Speaker, the Congress is to be congratulated for its action today in passing four bills that are keystones in our public health service. These bills bear the imprint of the House Interstate and Foreign Commerce Committee and I am honored to have shared in working on these vital programs.

Perhaps we did not go quite far enough with this legislation, but at least we kept the programs alive and moving. Although I would have preferred a higher level of funding, these are not the times to cling doggedly to spending programs.

These four bills extend, and in some cases, improve our Federal programs in the areas of mental health, migrant worker health, public health training and medical library assistance.

S. 2523, the mental health bill, not only extends existing programs, but takes steps toward dealing with the mental problems that are magnified by the excessive use of alcohol and drug addiction. It is only humane that we increase our efforts to deal with these problems that are hidden within the fibers of our society—yet real and increasing in scope. I am especially proud that this bill increases the Federal participation in dealing with mental problems dealing with children. In this way, perhaps we can reclaim some young lives before they are lost forever. I had hoped we might increase the Federal participation in the grant ratio to at least a matching status. However, I much prefer this much of the cake to none at all.

Providing health services for migratory agricultural workers and their burdgeoning families is both good and necessary action. H.R. 14733 will focus new light and bring new hope for the migrant workers. Also, we have extended and enlarged the coverage of the act that Congress initially passed 2 years ago. This program is vital to my district, especially. I am pleased to report that we have one of the finest migrant health centers in the Nation in San Marcos, Tex. This small band of dedicated workers is one of the more active groups in the United States.

In a time when the Nation is suffering from a shortage of trained technicians and professional people in the medical field, Congress accepted the responsibility of amending the Public Health Service Act to extend the authority making formula grants to schools of public health. Also, we added significantly to the trainee programs for professional public health personnel. Texas is blessed with many good medical schools and this bill, S. 2809, should only strengthen an already strong State program. Here again, we took a long overdue step when we amended the Public Health Service Act to improve and extend the provisions relating to assistance to medical libraries.

True, these bills are not perfect nor do they provide all the money that is needed. The significant thing, the meaningful thing is that these bills are at least a reassurance that Congress is taking notice of our Nation's health problems, physical and mental. We are aware of our neighbor's problems and we will not forget them.

Mr. SPRINGER. Mr. Speaker, will the gentleman yield?

Mr. STAGGERS. I yield to the gentleman from Illinois.

(Mr. SPRINGER asked and was given permission to revise and extend his remarks.)

Mr. SPRINGER. Mr. Speaker, some years ago the House recognized the plight of migrant agricultural workers in regard to health services. Seldom citizens of the places where they worked, they found no local health facilities open to them and no programs for any preventive medicine. This situation endangered both the migrants and the communities.

With the leadership and grant assistance provided by the program under consideration now the situation has been materially bettered. Literally hundreds of communities where migrants work have programs to provide health care and, since our last renewal of the law, emergency hospital services.

The bill we passed some time ago recognized another situation. The health of nonmigrant workers who labor along side the migrant can cause some of the very problems we had hoped to avoid. So where the health of the nonmigrant is so closely connected we allowed the use of funds for both on the same basis.

The Senate version varied but little from the House version of this program. Community and citizen participation in the formulation of these vital programs is a good thing. Certainly they cannot be administered by a committee system, and all knowledgeable elements of the community should have an interest in them and a chance to contribute to their success. The Senate version contained language to effect this and the conferees accepted. Otherwise the bill was taken as passed by the House.

We recommend that the conference report be adopted by the House.

Mr. STAGGERS. Mr. Speaker, I move the previous question on the conference report.

The previous question was ordered.

The conference report was agreed to.

A motion to reconsider was laid on the table.

CONFERENCE REPORT ON S. 2523, COMMUNITY MENTAL HEALTH CENTERS AMENDMENTS OF 1970

Mr. STAGGERS. Mr. Speaker, I call up the conference report on the bill (S. 2523) to amend the Community Mental Health Centers Act to extend and improve the program of assistance under that act for community mental health centers and facilities for the treatment of alcoholics and narcotic addicts, to establish programs for mental health of children, and for other purposes, and ask unanimous consent that the statement of the managers on the part of the House be read in lieu of the report.

The Clerk read the title of the bill.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from West Virginia?

There was no objection.

The Clerk read the statement.

(For conference report and statement, see proceedings of the House of February 25, 1970.)

Mr. STAGGERS (during the reading). Mr. Speaker, I ask unanimous consent to dispense with further reading of the statement.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from West Virginia?

There was no objection.

The SPEAKER pro tempore. The gentleman from West Virginia is recognized for 1 hour.

Mr. STAGGERS. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, the conference report we bring before the House today is on one of the most important health bills to be considered during this session of the Congress. Twenty-five years ago there were 462,000 resident patients in State and local government mental hospitals in the United States. By 1955 this number had grown to 559,000 patients, and if those trends had continued, we would today have over 800,000 patients in mental institutions. Instead, we have 300,000. This drastic drop is due to two reasons. The principal reason is the use of psychoactive drugs in the treatment of mental illness, but an important part has also been played by the substantial increase in trained medical manpower in the field of mental health.

Notwithstanding this progress, it still is a melancholy fact of life that one American in each 10, at present rates of admission to mental institutions, will spend some portion of his life confined to a mental institution. We have to do something about this, and this bill is intended to do just that.

The existing program of grants for construction and staffing of community mental health centers was established in 1963. Under this program, matching grants are made to the States following the Hill-Burton formula for meeting a portion of the costs of construction of community mental health centers. In addition, grants are made to meet a declining portion of the costs of professional and technical personnel staffing these facilities with the Federal assistance limited to 4 years and 3 months.

Based on our experience to date with

Statement by
Roger O. Egeberg, M.D.
Assistant Secretary for Health and Scientific Affairs
Department of Health, Education, and Welfare
before the
Subcommittee on Public Health and Welfare
House Committee on Interstate and Foreign Commerce
September 29, 1969

Mr. Chairman and Members of the Committee:

I am happy to appear before you today concerning legislation to extend the expiring authorization for project grants to improve health services for migrant agricultural workers and their families.

The bill under consideration today -- H.R. 13432, introduced by Mr. Rogers -- would extend for three additional years the grant authorizations in section 310 of the Public Health Service Act. For these three additional years the bill would authorize appropriations of $30 million for Fiscal Year 1971, $45 million for 1972, and $60 million for 1973. In addition, it includes an amendment to broaden the definition of program beneficiaries to include "other seasonal agricultural workers" and clarifying amendments relating to the purpose of the grants authorized and to the language authorizing the use of grant funds for the training of allied health personnel.

Background and Need

Migrant farmworkers and families present a unique problem in the planning and delivery of health care. They are unequally distributed over the Nation's States and counties. They reside in particular places for only brief periods each year. In each place they are strangers. Many -- although they have been American citizens for a generation or two -- still speak Spanish more easily than English. Some speak no English at all.

Wide dispersion in isolated areas, lack of familiarity with their temporary communities, fear of community hostility, unfamiliarity with modern health concepts and practices, voicelessness in community planning -- all conspire to make migrants forgotten citizens when it comes to local provisions of health and other services. Even when States and localities recognize their needs and try to plan for them, great difficulties are encountered. They are "here today and gone tomorrow", gone to some destination which is perhaps unknown even to themselves.

Over the years, some migrants have left migratory work in agriculture. They have either been displaced by machines that quickly and easily perform the work of thousands of human hands; or, they have found new job opportunities at permanent locations. But the need for a mobile supply of farm workers to meet the peak labor demands of hundreds of the Nation's agricultural counties continues. Only with a mobile labor supply can the American appetite for fresh fruit and vegetables that do not yet lend themselves to machine harvesting be satisfied. Furthermore, the market for the labors of the migrant force will continue, particularly in the new agricultural areas where there is little or no local labor supply.

The total number of migrant farmworkers and dependents appears likely to continue around one million, fluctuating annually according to weather, crop and market conditions. This estimate excludes at least an equal number of potential migrants who are as poor, as isolated from the community and as deprived of health care as the current migrant. Especially in the

home-base counties of Texas, Florida, California, Missouri, Arizona and New Mexico, the migrants of the past season merge with their equally impoverished neighbors, many of them families who have moved in the past and may migrate again next year.

The best clues to the health problems of the migrant population come from these home-based counties. Here 18 percent of the babies are born at home and the infant mortality rate is conservatively estimated at one-fourth higher than the national average. Parasitic infestations and tuberculosis -- conditions associated with poverty, poor nutrition and poor environment -- are common. Iron deficiency anemia is prevalent, and nutritionally based diseases such as beriberi, pellagra, scurvy, and rickets are occasionally found. Dental decay is almost universal.

Yet the counties where the problems are most severe are seriously handicapped by shortages of health manpower to deal with them. The ratios of physicians and dentists to the population of these counties are less than half the national average. The counties as a whole have median family incomes averaging about three-fourths of the national median.

Accomplishments under the Migrant Health Act

The Migrant Health Act was devised to make health care accessible to migrants through helping States and communities adapt their health care system to the migrant's unique situation and need. In striking contrast to the half-dozen isolated community efforts of six years ago, now 117 single or multi-county grant-assisted projects serve migrants in 35 States and Puerto Rico. They provide actual medical, dental, and related

health services in places and under conditions which make them easily accessible. They are used by migrant workers and their families, at home and on the road.

A typical project operates one or more family health service clinics during the season or year round, depending on whether the project serves a northern work area or a home-base where migrants move in and out throughout the year. The clinics are open at least once or twice weekly, usually during the evening, so that workers as well as family dependents can use the service. Some projects have mobile units, but most are set up temporarily in churches, school buildings, labor camp units or outlying public health facilities. One or more physicians, nurses, technicians and aides may travel from 10 to 50 or more miles for the evening's work in these clinics.

The clinic sessions bring preventive and remedial health care to the migrants at times and places which make it readily accessible for use. Typically, they are supplemented by arrangements with local physicians or hospital outpatient departments which provide emergency care between clinic sessions. They treat all family members for whatever illnesses, injuries or other needs they present, referring patients for further special care if necessary.

The medical services are supported by an active outreach through nurses and aides who visit migrants in their homes for early casefinding, health counselling, necessary referral, and post-treatment follow-up. Support is also received from sanitarians concerned with removal of health hazards at the home and work sites.

We encourage participation of migrant families in planning for services to meet their expressed needs and desires. We also encourage project staff members to consider each contact with a migrant as an opportunity for health counselling. Some projects conduct systematic health education programs on a group basis to supplement informal individual counselling.

Nearly 1,000 physicians are now serving migrants through 225 family health service clinics supplemented by care in their own offices or in hospitals. An estimated 325,000 migrants lived in counties served by projects for at least part of the 12 months' period ending last June 30. During the year 210,000 medical visits and 28,000 dental visits were made and 3,600 migrants were hospitalized. In addition, nurses and aides to nurses made 160,000 casefinding and health counselling visits to labor camps, other migrant home sites, schools and day care centers serving migrant children. Sanitarians and sanitation aides made 120,000 visits to migrant housing for inspection and follow-up to see that housing deficiencies were corrected. Sanitation staff members are now starting to make similar visits to work sites in fields and packing sheds to see that toilets, safe drinking water, and water for handwashing are provided.

Migrant health projects provide not only remedial care to all family members but also immunizations, family planning services, nutrition counseling, and other health maintenance services. Project staff members work with growers and other community groups to improve housing and environmental conditions; and to develop better understanding and acceptance of migrants as people.

Finally, they work directly with migrants, to teach and encourage good homemaking and safety practices, and to provide better understanding of health services and their effective use.

Funds for hospitalization under the auspices of migrant health projects became available for the first time in 1967. Currently about half the projects provide hospital care in addition to other services under the provisions of the 1965 and 1968 extensions of the Migrant Health Act.

Many communities and individuals have invested their own time, facilities, equipment, funds and other items essential to the provision of project services. An average of 40 percent of project support--in cash and in kind--has come from other than migrant health grant sources.

Within the last month, with assistance from the Public Health Service staff, the national organization of more than 400 orders of Catholic sisters in the United States has adopted a national plan for involvement of their trained teachers, nurses, and social workers in services to migrants. The Sisters will volunteer their services through existing projects and will help to organize services where they are deficient. They will be a much needed source of additional professional manpower in needy rural areas where an influx of migrants creates an almost overwhelming problem.

Continuing needs

In spite of the progress made, two-thirds of the Nation's 900 counties where migrants live temporarily still have no grant-assisted services. The services provided by existing projects are heavily utilized; however,

services provided to migrants in project areas have averaged less than one medical visit per person per year compared with the national average of more than four visits per person per year. Dental visits per migrant have averaged about one-twentieth of the national per capita average. The amount spent per migrant in migrant health project areas totalled about $12 last year including funds from all sources, compared with a national per capita health expenditure of about $250.

Specific improvements needed include:

1. Additional family health service centers established in or near large migrant labor camps or other points of migrant labor concentration.
2. Improvement of the quantity and comprehensiveness of dental as well as medical services for all family members.
3. Increased "outreach" services through nurses and aides for casefinding and health counselling.
4. Increased assistance by professional health educators to strengthen the health education component of migrant health services.
5. Intensified sanitation services to improve migrants' living and working environment.
6. Addition of medical social service, nutrition counselling, and homemaker services.
7. Recruitment from among migrants and ex-migrants of greatly increased number of aides to help relieve professional health manpower shortages and to establish more effective liaison working relationships with migrants.

8. Improved arrangements for post-hospital follow-up and services.

Before commenting upon the provisions of the legislation under consideration by this Committee, Mr. Chairman, I wish to express my own deep concern and that of this Administration with the health problems of the migrant and his family. As evidence of this and our commitment to the task of improving the health of these people, we are currently considering a number of alternatives which will increase the effectiveness of our efforts to solve the migrants' unique health care problems.

As you know, Mr. Chairman, Secretary Finch has appointed a blue-ribbon task force to review the Medicaid program in its entirety. This group is currently considering our entire commitment to the migrant worker, and is investigating the possibility of including such persons within the scope of Medicaid benefits. Also under consideration is a proposal which would consolidate the migrant health activities of DHEW with the "Partnership for Health" program. This proposal would provide for the setting aside of funds under Section 314(e) of the PHS Act specifically for Migrant Health Projects. This would be consistent with our desire to consolidate and simplify the present proliferation of grant authorities, yet give the special attention to migrant health that is required. Furthermore, the President's proposed Family Assistance Plan, when enacted into law, will have an impact on the health of migrant workers by increasing the income of migrants, thereby ameliorating that part of the unique migrant health problems caused by lack of money.

Therefore, in view of these new program needs and directions, Mr. Chairman, we support the extension of the existing grant legislation; however, we would like to recommend that the extension be for two years rather than for three, as provided in H.R. 13432. We anticipate that viable alternatives will become evident, and would be appropriate for Congressional review within that time. As for the proposed increases in the annual appropriation authorizations, it appears unlikely at this time that prevailing budgetary and expenditure constraints will permit such a rapid expansion in the funding of this program. We would therefore recommend that the specific annual authorizations be replaced with an indefinite authorization--i.e., "such sums as may be necessary."

With respect to the remainder of the provisions of H.R. 13432, we do not consider it necessary to provide specifically for grants to train persons in allied health professions since the present language already provides ample authority for appropriate training activities for people to function in migrant health projects. Furthermore, we believe that extending the services provided under section 310 to "other seasonal agricultural workers" would tend to confuse the identity of the intended beneficiaries of the program and, therefore, we recommend its deletion from the bill. We also believe that the term "provide continuity" in sub-section (c) of H.R. 13432 is already contained within the concept of "improvement" in the present language of section 310. Hence, we see no need to add the proposed term.

This concludes my formal statement, Mr. Chairman, but my associates and I would be happy to answer any questions your Committee may have in mind.

Statement by
Roger O. Egeberg, M.D.
Assistant Secretary for Health and Scientific Affairs
Department of Health, Education, and Welfare
before the
Subcommittee on Health
Senate Committee on Labor and Public Welfare
October 21, 1969

Mr. Chairman and Members of the Committee:

I am happy to appear before you today concerning legislation to extend the expiring authorization for project grants to improve health services for migrant agricultural workers and their families.

The bill under consideration today -- S. 2660 introduced by you, Mr. Chairman and other members of the Subcommittee -- would extend for five years the grant authorizations in section 310 of the Public Health Service Act. For these five additional years the bill would authorize appropriations of $20 million for Fiscal Year 1971, $25 million for 1972, $30 million for 1973, $35 million for 1974, and $40 million for 1975.

Background and Need

Migrant farmworkers and families present a unique problem in the planning and delivery of health care. They are unequally distributed over the Nation's States and counties. They reside in particular places for only brief periods each year. In each place they are strangers. Many --although they have been American citizens for a generation or two -- still speak Spanish more easily than English. Some speak no English at all.

Wide dispersion in isolated areas, lack of familiarity with their temporary communities, fear of community hostility, unfamiliarity with modern health

concepts and practices, voicelessness in community planning -- all conspire to make migrants forgotten citizens when it comes to local provision of health and other services. Even when States and localities recognize their needs and try to plan for them, great difficulties are encountered. They are "here today and gone tomorrow", gone to some destination which is perhaps unknown even to themselves.

Over the years, some migrants have left migratory work in agriculture, displaced by machines that quickly and easily performed the work of hundreds of human hands. But the need for a mobile supply of farm workers to meet the peak labor demands of hundreds of the Nation's agricultural counties continues. Only with a mobile labor supply can the American appetite be satisfied for fresh fruits and vegetables that do not yet lend themselves to machine harvesting. The total number of migrant farmworkers and dependents appears likely to continue around one million, fluctuating annually according to weather, crop and market conditions.

The best clues to the health problems of the migrant population come from the counties the people consider "home". Here 18 percent of the babies are delivered by midwives and the infant mortality rate is conservatively estimated at one-fourth higher than the national average. Parasitic infestations and tuberculosis -- conditions associated with poverty, poor nutrition and poor environment -- are common. Iron deficiency anemia is prevelent, and nutritionally based diseases such as beriberi, pellagra, scurvy, and rickets are occasionally found. Dental decay is almost universal.

Yet the counties where the problems are most severe are seriously handicapped by shortages of health manpower to deal with them. The ratios of physicians and dentists to the population of these counties are less than half the national average. The counties as a whole have median family incomes averaging about three-fourths of the national median.

Accomplishments under the Migrant Health Act

The Migrant Health Act was devised to make health care accessible to migrants through helping States and communities adapt their health care system to the migrant's unique situation and need. In striking contrast to the half-dozen isolated community efforts of six years ago, 117 single or multi-county grant-assisted projects are serving migrants in 35 States and Puerto Rico at the present time. The projects provide medical, dental, and related health care in places and under conditions which make the services easily accessible.

A typical project operates one or more family health service clinics during the season or year round. Projects in northern work areas usually operate only for the duration of migrants' employment in the area. Those in home-base communities usually operate year round since migrants move in and out throughout the year. The clinics are open at least once or twice weekly, usually during the evening, so that workers as well as family dependents can obtain remedial and preventive health care. Some projects have mobile medical units, but most operate their clinics in churches, school buildings, labor camp units or other temporary facilities near the places where the people live. One or more physicians, nurses, technicians and aides travel

from 10 to 50 or more miles for each evening's work in these clinics.

Clinic physicians treat all family members for whatever illnesses, injuries or other needs they present, referring patients for further special tests or treatment if necessary. Immunizations, family planning services and nutrition counseling are equally as important as the treatment provided. Typically, the clinics are supplemented by arrangments with local physicians or hospital outpatient departments to provide emergency care between clinic sessions

The medical services are supported by an active outreach through nurses and aides who visit migrants in their homes for early casefinding, health counselling, necessary referral, and post-treatment follow-up. Support is also received from sanitarians concerned with the removal of health hazards at the home and work sites.

Projects encourage the participation of migrant families in planning for services to meet their expressed needs and desires. Many staff members consider each contact with a migrant as an opportunity for health counselling. Some projects conduct systematic health education programs on a group basis to encourage good homemaking and safety practices, and to develop better understanding of health services and their use.

Nearly 1,000 physicians are now serving migrants through 225 family health service clinics supplemented by care in their own offices or in hospitals. An estimated 325,000 migrants lived in counties served by projects for at least part of the 12 months' period ending last June 30. During the year

they made 210,000 medical visits and 28,000 dental visits to project facilities. In addition, nurses and nurse aides made 160,000 casefinding and health counselling visits to labor camps, other migrant home sites, schools and day care centers.

Many labor camps now have safe water supplies, improved toilet facilities, and more adequate shelters as the result of more than 100,000 field inspections and follow-up visits made by sanitarians and sanitation aides last year.

Funds for hospitalization under the auspices of migrant health projects became available for the first time in 1967. Currently about half the projects provide hospital care in addition to other services under the provisions of the 1965 and 1968 extensions of the Migrant Health Act. Last year 3,600 migrants were hospitalized under project auspices.

Many communities and individuals have invested their own time, facilities, equipment, funds and other items essential to the provision of project services. Project staff members are constantly working with growers, hospital administrators, medical societies, civic organizations, and other public and private groups toward this end. An average of 40 percent of project support -- in cash and in kind -- has come from other than migrant health grant sources.

Within the last month, with assistance from the Public Health Service staff, the national organization of more than 400 orders of Catholic sisters in the United States has adopted a nationwide plan for involvement of their trained teachers, nurses, and social workers in services to migrants. The Sisters will volunteer their services through existing projects and will help to

organize services where they are deficient. They will be a much needed source of additional professional manpower in rural areas where an influx of migrants creates an almost overwhelming problem.

Continuing needs

In spite of the progress made, two-thirds of the Nation's 900 counties where migrants live temporarily still have no grant-assisted services. The services of existing projects are heavily utilized, yet they are far from adequate. On the average each migrant experiences one-fourth as many medical visits and one-twentieth as many dental visits annually as the average person in the United States. Health expenditures per migrant in project areas totalled about $12 last year, including funds from all sources, compared with a national per capita health expenditure of about $250.

Some of the specific improvements needed include:

1. Additional family health service centers established in or near large migrant labor camps or other points of migrant labor concentration.
2. Improvement of the quantity and the comprehensiveness of dental as well as medical services for all family members.
3. Increased "outreach" services through nurses and aides for casefinding and health counselling.
4. Increased assistance by professional health educators to strengthen the health education component of migrant health services.
5. Intensified sanitation services to improve migrants' living and working environment.

6. Addition of medical social service, nutrition counselling, and homemaker services.
7. Recruitment from among migrants and ex-migrants of greatly increased numbers of aides to help relieve professional health manpower shortages and to establish more effective liaison working relationships with migrants.
8. Improved arrangements for hospitalization including post-hospital follow-up and services.

Before commenting upon the provisions of the legislation under consideration by this Committee, Mr. Chairman, I wish to express my own deep concern and that of this Administration with the health problems of the migrant and his family. The Administration considers this a high priority program and this year is asking full authorization of $15 million for funding programs of health assistance to migrant workers and their families. The House has reduced this request back to the 1969 level of $8.1 million, and the Administration is appealing this before the Senate. As further evidence of our commitment to the task of improving the health of these people, we are currently considering a number of program alternatives which will increase the effectiveness of our efforts to solve the migrants' unique health care problems.

As you know, Mr. Chairman, Secretary Finch has appointed a blue ribbon task force to review the Medicaid program in its entirety. This group is currently considering our entire commitment to the migrant worker, and is investigating the possibility of including such persons within the scope of Medicaid benefits. Also under consideration is a proposal which would

consolidate the migrant health activities of DHEW with the "Partnership for Health" program. This proposal would provide for the setting aside of funds under Section 314(e) of the PHS Act specifically for Migrant Health Projects. This would be consistent with our desire to consolidate and simplify the present proliferation of grant authorities, yet give the special attention to migrant health that is required. Furthermore, the President's proposed Family Assistance Plan, when enacted into law, will have an impact on the health of migrant workers by increasing the income of migrants, thereby ameliorating that part of the unique health problems caused by lack of money.

Therefore, in view of these new program needs and directions, Mr. Chairman, we support the extension of the existing grant legislation; however, we would like to recommend that the extension be for two years rather than for five, as provided in S. 2660. We anticipate that viable alternatives will become evident, and would be appropriate for Congressional review within that time. As for the proposed increases in the annual appropriation authorizations, in the light of prevailing budgetary and expenditure constraints and uncertainties, we recommend that the specific annual authorizations be replaced with an indefinite authorization -- i.e., "such sums as may be necessary."

This concludes my formal statement, Mr. Chairman, but my associates and I would be happy to answer any questions your Committee may have in mind.