MIGRANT HEALTH PROGRAM

CURRENT OPERATIONS AND ADDITIONAL NEEDS

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service

90th Congress
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COMMITTEE PRINT

MIGRANT HEALTH PROGRAM

Current Operations and Additional Needs

PREPARED FOR THE

SUBCOMMITTEE ON MIGRATORY LABOR

OF THE

COMMITTEE ON LABOR AND PUBLIC WELFARE

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LETTER OF TRANSMITTAL

Senator Lister Hill, chairman, Senate Committee on Labor and Public Welfare

The history of health services to migrant farm families has been written in neglect. Until the passage of the Migrant Health Act in 1962, the unique problems of migrants were only rarely met by Government health programs. The poverty and mobility of migrants kept them apart from private medical services in rural communities.

A dramatic change has taken place in the 5 years since the Congress passed the Migrant Health Act. The following report summarizes the achievements of health programs that are laying a firm base for medical services to migrant families in farming communities across the country. But this report also points to the work yet to be done if the health needs of these people are to be met. Our task is far from finished.

Sincerely,

WILLIAM H. STEWART,
Surgeon General, Public Health Service.

FOREWORD

Five years ago, health neglect was the rule among migrants, on the part of the migrant himself and on the part of communities that depend on his labor. Shadowy and unseen, he passed through these communities with little note taken of his presence unless an epidemic or personal health emergency called him forcibly to attention.

The Migrant Health Act of 1962 brought hope that communities could start to provide migrant workers and their families the health care and protection most other families in the Nation enjoy.

The need was undeniable. Even a casual observer in migrant camps could see workers too sick or disabled to do a full day's work, and children who risked lifelong handicaps because preventive and remedial care was not readily available. Health *services* were needed—not studies.

The problems in meeting the need were immense. The personal fears of the migrant made him reluctant to impose himself and his need on a hostile community. Even if his fears were overcome, he lacked knowledge of acceptable health concepts and practices; he was isolated from communities; and he was only a transient in each of his temporary "homes." Finally, he was poor. All of these factors combined to make him an "excluded American" for health as well as other community services. Moreover, his typical "home" community was rural, lacking in health resources, and inclined to look upon "outsiders" with a jaundiced eye. These community factors added to the barriers between the migrant and the health care he needed.

With 5 years of experience behind the migrant health program, no longer is there a scant handful of communities with effective systems to extend health services to migrants. By August 1, 1967, 112 public or private nonprofit community organizations were using migrant health grants to help them provide medical, nursing, hospital, health education, and sanitation services to their seasonal migrants. Hundreds of State and local people and their organizations were adding resources of their own to the grant funds made available by the Public Health Service.

The work is well begun; and the services of different project areas are being linked together so that duplication of effort and gaps in service can be eliminated. Still the need has not ended. Service coverage remains weak in many of the areas where projects are now receiving grant assistance. Three-fifths of the counties identified as migrant home-base or work areas are still untouched.

Comprehensive health service planning provided through Public Law 749 last year shows promise for making improved health care accessible to all citizens. At present, however, State Governors are still in the process of naming planning agencies. It is unrealistic to assume that the complexities of providing migrant health services can immediately be woven into this new fabric. For at least 5 more years communities and States will continue to need migrant health grant assistance. A sound beginning has been made. The migrant health program must be continued and strengthened, not snuffed out.

MIGRANT HEALTH PROGRAM GOALS

- PROVIDE HEALTH SERVICES
- IMPROVE ENVIRONMENT

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APPENDIX

Migrant Farm Families and the Migrant Health Program

The goal of the migrant health program is to raise the health status of migratory farmworkers and their families to that of the general population. Subgoals are—

(1) To provide comprehensive health services with continuity as people move:

(*a*) By extending community services to migratory families—

Wherever they are;

For as long as they stay;

At times, at places, and under conditions which make the services easily accessible and thus readily used;

(*b*) By linking the services of different areas serving the same people to avoid duplication or gaps in health care.

(2) To improve migrants' environment to assure them of healthful, safe living and working conditions wherever they are.

The working guidelines for the program include:

Help the migrant to help himself.

Help communities recognize and assume their responsibility to include migrants in health service planning for the total community.

Promote the development of health services adapted to migrants and their environment.

Fully utilize available public and private resources.

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Target Population

1 Million Men, Women, and Children

a nationwide problem

More than 700 of the Nation's 3,100 counties depend on the labor of farmworkers from outside the local area during the peak harvest season. One million men, women, and children move annually in response to this need.

Migrant farmworkers are not commuters. They travel so far from their homes that they must establish a temporary residence in one or more other locations during each crop season. All family members may work when work is plentiful.

The reservoir population from which migrants are drawn includes an estimated 1 million additional persons. Some enter and others leave the migrant farm labor force each year. The replacements are consistently from among those most afflicted with the social and economic handicaps that characterize farm migrants:

Minority group status.—The people belong chiefly to Spanish-speaking, Negro, Indian, and low-income "Anglo" minorities.

Poverty.—Annual income from all sources averaged $1,400 per migrant worker in 1965; that of nonmigrant seasonal farmworkers was even less.

Lack of education.—The average migrant adult has achieved the fifth grade.

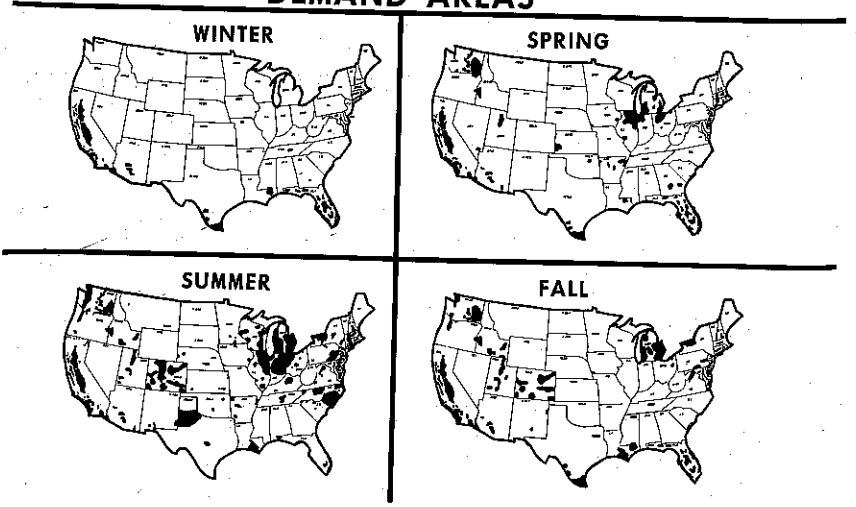
Lack of readily marketable skills.—Migrants are skilled in agriculture but inexperienced and unskilled in other work.

Poor environment.—With minor exceptions, their housing is characterized by slum conditions in both their home base and their work communities.

Community rejection.—Even in their "home" communities they are often not accepted.

The migrant has the added handicap of mobility. Always a stranger and an outsider, he "belongs" to no community. Even the place he calls home often does not consider him one who "belongs."

MAJOR AGRICULTURAL MIGRANT LABOR DEMAND AREAS



Except During the Off-Season, "Home" Is Where the Crops Are

The number of people involved, multiplied by the average number of times they move each year, is a rough indicator of the scope of the migrant problem. On the average, the people live and work in two or three locations annually. They may move several times from farm to farm or camp to camp at each location.

In the winter, migrant work areas are heavily compressed in the extreme South. Some cannot find work at this time and simply return to their homes to pick up whatever odd jobs they can find until the next season starts. Many cannot find employment anywhere.

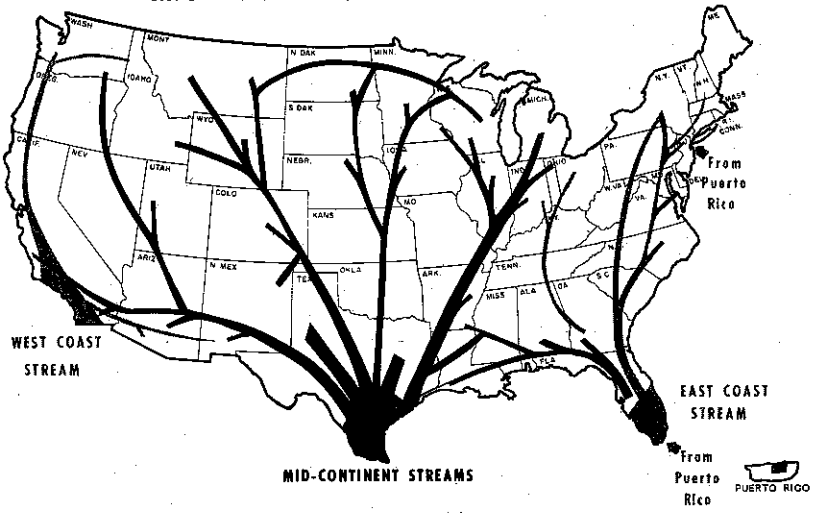
By April, work opportunities have started to open in some northern localities.

In the late summer and fall, many small northern communities are swamped with "strangers" who have come to help harvest their fruits and vegetables.

Home-base areas to which migrants return when no work is available elsewhere are not shown on the migrant labor demand area maps unless they are also labor-using areas. Thousands of migrants return during the off-season to counties of Texas, New Mexico, Mississippi, and other States which offer them little or no agricultural employment. Here they merge with thousands of other unemployed or underemployed seasonal farmworkers like themselves.

Some migrant labor demand areas are essentially year-around agricultural work areas which require greatly increased numbers of workers at peak seasons. This is true of many of California's agricultural areas where there is a constantly recurring ebb and flow of labor throughout the year.

TRAVEL PATTERNS OF SEASONAL MIGRATORY AGRICULTURAL WORKERS



Migrants' movement flows north and south with the seasons in fairly well-established patterns, generally called migratory streams. Negroes from the Southeastern States comprise the largest single group on the east coast. They are supplemented by Spanish-speaking migrants from Puerto Rico and Texas, and a few Anglo-Americans.

The midcontinent and west coast streams are comprised chiefly of Spanish-speaking families from Texas and the Southwest. South Texas is the population reservoir from which at least 30 other States draw much of their seasonal farm labor supply.

At Each of Their Temporary "Homes" Migrants Need —

- ACCESS TO HEALTH SERVICES
- A SAFE HOME AND WORK ENVIRONMENT

But Migrants' Homebase and Work Communities are Typically —

- RURAL
- ISOLATED
- LACKING IN ECONOMIC RESOURCES
- LACKING IN HEALTH RESOURCES

The local supply of physicians, dentists, and hospital beds falls far below national averages in most of the communities. In some areas, local poverty severely restricts health services for all persons—especially for migrants.

Item	Rural areas	National average
Physicians per 100,000 population	59.1	150.8
Dentists per 100,000 population	27.4	54.1
Hospital beds per 1,000 population (short-stay hospitals)	2.0	3.8
Median family income	[1] $4,400	$5,660

[1] Data for the first 3 items are for isolated rural areas; data for median family income represent all rural areas.

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The Typical "Homes" Migrants Live In—

- ARE SMALL, OVERCROWDED, AND OF SUBSTANDARD CONSTRUCTION
- LACK ADEQUATE FACILITIES FOR FOOD STORAGE AND PREPARATION
- LACK ADEQUATE AND SAFE WATER SUPPLY FOR DRINKING, DISHWASHING, BATHING, AND LAUNDRY
- LACK ADEQUATE SEWAGE AND WASTE DISPOSAL FACILITIES
- ATTRACT INSECTS AND RODENTS
- HAVE NO RECREATION AREA OR FACILITIES

The Typical Places Where They Work—

- ARE EXPOSED TO HEAT, COLD, WIND, DUST, CHEMICALS, AND MECHANICAL HAZARDS
- LACK SAFE AND ACCESSIBLE WATER FOR DRINKING OR WASHING
- LACK ADEQUATE TOILET FACILITIES

HOUSING

Profile of camps in one State, 1966:
- Number of camps: 760.
- Number of camps approved: 432.
- Average occupancy: 20 to 25 persons.

Deficiencies:
- Total number: 717.
- Campsite (general conditions, safety hazards): 79.
- Building disrepair, lack of sufficient doors or windows: 56.
- Poor mattresses, not enough beds: 28.
- Absence or disrepair of screens: 102.
- Insanitary privies; privies in disrepair: 245.
- Insanitary storage and improper disposal of garbage and refuse: 146.
- Water supply, improper well construction: 14.
- Others: 47.

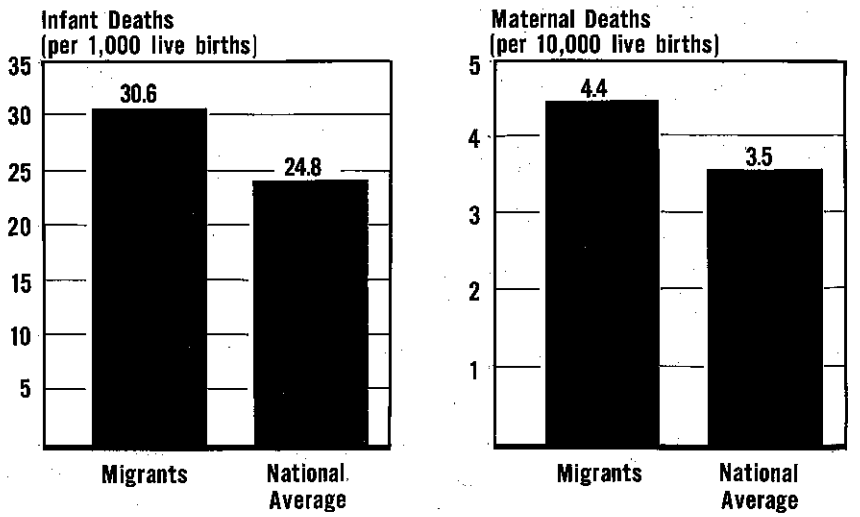
WORKING CONDITIONS

Usually farmwork is done where no water supplies or toilet facilities are available, even though long hours are spent in the fields.

HEALTH STATUS-1

MORTALITY – 1964

Migrants Compared with National Averages



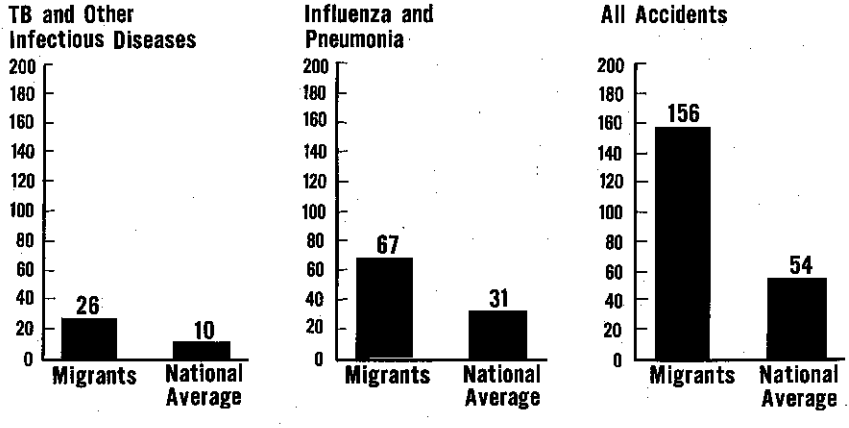
Even with the improvements in their infant and mortality rates in recent years, migrants still lag far behind the national average. Their infant mortality in 1964 was at the level of the United States as a whole in 1949. Their maternal mortality rate was the same as the national average a decade ago.

HEALTH STATUS-2

MORTALITY – 1964

Migrants Compared with National Averages

(Rates per 100,000 Population)



The accident mortality rate for migrants in 1964 was nearly three times the U.S. rate. It was 60 percent greater than the U.S. rate 30 years ago. Lesser disparities are shown in the mortality rates for tuberculosis and other infectious diseases, and for influenza and pneumonia. However, the differences are still great. Migrants' 1964 mortality from tuberculosis and other infectious diseases was 2½ times the national rate, approximating the national average a dozen years ago. Their mortality from influenza and pneumonia was more than twice the national rate, and slightly in excess of the U.S. rate for 1940.

The Migrant's Road to Health Care is Beset with Obstacles

On the side of the migrant - -

- POVERTY
- LACK OF HEALTH KNOWLEDGE
- ISOLATION
- FEAR OF NON-ACCEPTANCE

On the side of the community - -

- LEGAL RESTRICTIONS AGAINST SERVING NONRESIDENTS
- LEGAL EXCLUSION FROM PROTECTIVE LEGISLATION
- HEALTH PLANNING PRIORITIES THAT EXCLUDE MIGRANTS
- INADEQUATE HEALTH MANPOWER
- INADEQUATE FINANCIAL RESOURCES
- PROBLEMS OF SERVING A MOBILE GROUP
- RESISTANCE TO MINORITY GROUPS, ESPECIALLY MIGRANTS

Migrants' Health Conditions Reflect Personal and Community Neglect———

- Untended illnesses and injuries
- Uncared for remediable defects
- Needless deaths

These Conditions and Lack of Care Add Up to Needless Economic and Social Costs for Migrants, for Their Temporary Communities, and for the Nation

79-074 O-67-4

The Migrant Health Act Provides

- HEALTH SERVICES
- CONSULTATION
- PROGRAM TOOLS

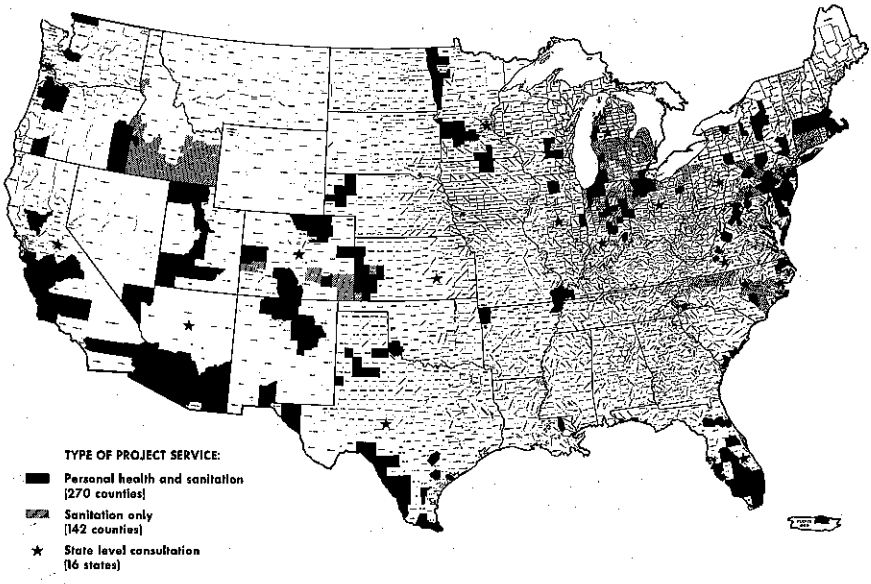
To Meet Migrants' Health Needs

THE MIGRANT HEALTH ACT PROVIDES ASSISTANCE TO MEET MIGRANTS' NEEDS

Health services	Medical and dental treatment. Immunizations and other preventive care. Early casefinding by nurses and aids. Health education. Sanitation services. Hospital care (added in 1967).
Consultation	Community organization. Medical. Nursing. Health education. Hospital administration. Sanitation. Social science. Program administration and evaluation.
Program tools	Guidelines for project development. Health education films adapted to migrant situation. Personal health record forms. Migrant housing plans. Exhibits. Information.

HEALTH SERVICES PROVIDED — JANUARY 1967

MIGRANT-IMPACT COUNTIES WITH GRANT-ASSISTED HEALTH SERVICES



Within a year after the first migrant health grant appropriation was made in the spring of 1963, 42 applicants had been awarded migrant health grants to pay part of the cost of health services for migrants. The number of projects more than doubled by January 1967, when 94 projects were in operation.

Two-thirds of the migrant health grants have been made to State or local health departments. The other third have been made to local migrant councils, local governing bodies, hospitals, county medical societies, and schools of medicine.

One or more migrant health projects operate in 36 States and Puerto Rico. Each project serves migrants in from one to 20 counties. Community-based projects offer personal health care to migrants in about two-fifths (270) of the 726 counties thus far identified as migrant work or home-base areas. They offer sanitation services in most of these and an additional 142 counties.

Services in home-base areas have been emphasized. About 40 home-base counties reporting an estimated outmigration of 200,000 persons are included in migrant health project areas in southern Florida, Texas, New Mexico, Arizona, southern California, and the bootheel of Missouri.

Continuity of care becomes more possible as project services are provided at strategic points along major migration routes. Personal health records carried by the migrants facilitate continuity and help to avoid duplication or gaps in services. Project reports indicate that from 10 to 90 percent of the migrants contacted present a personal health record upon request. Project reports are also showing results from the use of interarea referral forms.

State-level consultation projects employ one or more persons on the staff of 16 State health departments. These persons provide information and assistance on migrant health matters to persons within or outside the State. They are active in county-level program development, organization of orientation programs for State and local staff members involved in migrant health and related activities, evaluation of project services, operation of interarea referral systems within and between States, and other program matters.

A few State-level projects provide sanitation, nursing, or other services throughout the State wherever a major migrant influx exists. This is most likely to be true in the case of sanitation services.

Health Services Assisted by Migrant Health Grants

Distribution of Grant Dollars by Type of Service 1963 — 1967

Fiscal Year	Grant Funds Available and Awarded	Distribution	
		Personal Health Care Percent	Sanitation Services Percent
1963	$ 750,000	91	9
1964	1,500,000	91	9
1965	2,500,000	90	10
1966	3,000,000	90	10
1967	7,200,000	90	10
	$14,950,000	90	10

In each fiscal year since the program started, the entire amount available for grants has been awarded. Contributions to projects from other sources have had a reported value of nearly $10 million—40 percent of total project costs. These contributions include the value of contributed services, equipment, facilities, and other items essential to project operation.

Health Services Offered by Projects at Camps or Other Places Accessible to Migrants

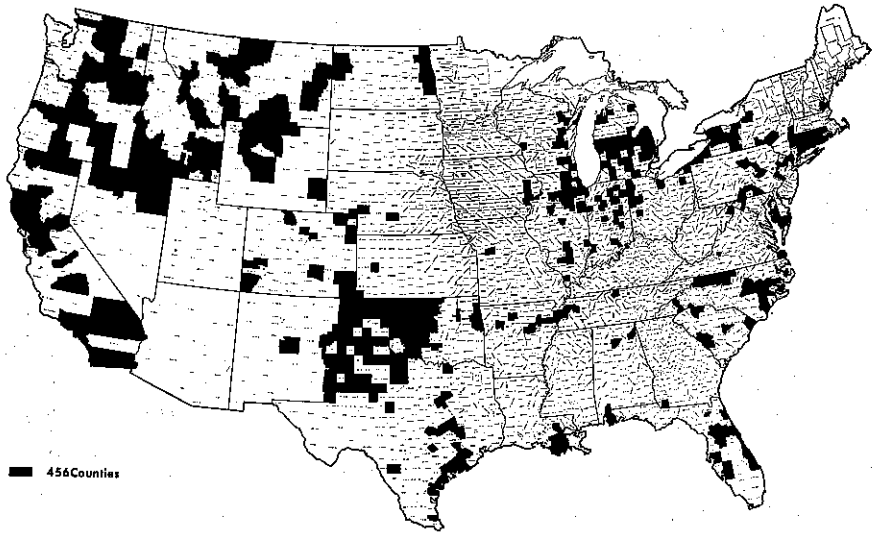
Health services offered by grant-assisted migrant health projects during 1966; estimated projections for 1967 and 1968

	1966	1967 estimate	1968 estimate
Migrants:			
Total number, United States	1,000,000	1,000,000	1,000,000
Number in project areas at some time during year	250,000	300,000	350,000
Counties with migrant influx:			
Total number, United States	726	726	726
Number offering grant-assisted services:			
Personal health and sanitation (combined)	270	280	300
Sanitation only	142	150	150
Personal health services provided migrants: [1]			
Medical visits	165,000	215,000	265,000
Dental visits	18,000	24,000	30,000
Hospital patients	0	4,200	5,700
Hospital patient days	0	29,400	39,900
Nursing visits to camps, etc	100,000	125,000	150,000
Sanitary inspections and followup visits	100,000	125,000	150,000
Appropriation:			
Health service support	$3,000,000	$7,200,000	$8,100,000
Consultation and program tools	$500,000	$800,000	$800,000

[1] Health education is potentially a part of every service. Data are not separately reported.

HEALTH SERVICE DEFICIENCIES – JANUARY 1967

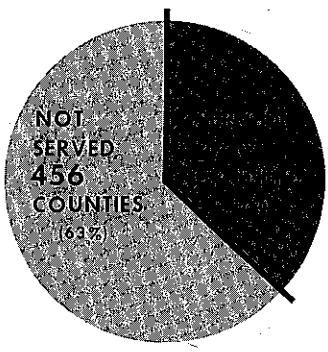
MIGRANT-IMPACT COUNTIES LACKING GRANT-ASSISTED HEALTH SERVICES



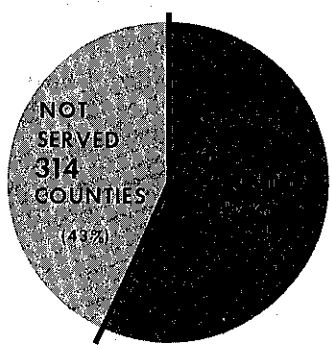
For continuity of health care and protection, migrants need access to health services in every county where they live and work temporarily. Because geographic coverage by project services is still far from complete, a total of 750,000 migrants had no access to personal health care provided through projects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

HEALTH SERVICE DEFICIENCIES

Personal Health Care



Sanitation Service



Only one out of three counties with migrants offered grant-assisted personal health care geared to the special needs of migrants during 1966. Only six out of 10 counties offered protection of their living and working environment through sanitation services with grant assistance. Lack of continuity of health care will remain a problem as long as many communities have no place to which a migrant can turn and expect to find needed health care.

Health Service Deficiencies

Personal health services rendered by projects to migrants* compared with national utilization rates

- **MEDICAL VISITS PER PERSON PER YEAR**

Migrants (1966)	.66
National average (1963- 64)	4.5

- **DENTAL VISITS PER PERSON PER YEAR**

Migrants (1966)	.07
National average (1963 - 64)	1.6

* Data are for the 250,000 migrants in project areas at some time during 1966.

To gain health status comparable to the national average, migrants must be able to obtain health care at at least the levels achieved by the general population. Medical and dental visits by the 250,000 migrants present in project areas for part of 1966 averaged far below the national average. Furthermore, the acute needs of migrants in project areas suggest that they obtained relatively little care elsewhere.

The low migrant rates reflect the intermittent and temporary nature of migrants' access to projects and their services, the newness of some projects just getting underway in 1966 and the typical local shortage of project physicians and dentists to meet more than emergency needs. Although the general shortage of health manpower was a contributing factor, project services might have been expanded in many localities if additional funds had been available.

Health Service Expenditures Per Capita

Migrants compared with national average

Item	MIGRANTS (1967)			National average (1965)
	Migrant Health Grant Funds	Funds from Other Sources	Total	
Personal health care	$6.48	$4.32	$10.80	$209.40
Sanitation services	.72	.48	1.20	—*
Total	7.20	4.80	12.00	209.40

* Not available

National per capita personal health expenditures are nearly 20 times the per capita expenditures for migrants through grant-assisted projects. Although some health care is purchased by migrants or provided by communities where no grant-assisted project exists, project experience indicates that such care is minimal. As an example, among 459 persons surveyed by a midwestern project, only one out of four had ever visited a dentist. Yet nearly all showed need for dental care. Twenty percent needed emergency care.

Steps to Meet Migrant Health Program Goals

GOAL

Health status of migrants raised to level of general population

STEPS TAKEN

Problem is better identified; tools are being developed for measuring health improvement.

1966 services --

Reached 270 counties having a 250,000 migrant influx.

Included 183,000 patient - visits for medical or dental care;
100,000 nursing visits for casefinding and follow-up;
100,000 sanitation visits to upgrade housing and work environment

STEPS NEEDED *

Improve access of migrants to comprehensive health services.

Improve data system to better define problem; measure program effectiveness; determine needs outside project areas.

Serve potential as well as actual migrant. **

* All would require renewal of legislation and additional funds to meet goal.

** Serving potential migrant would require a broadened definition of term "migrant".

The migrant health program is establishing checkpoints and adapting its project reporting system to better measure health improvement. The data system must take into account mobility and population turnover. Some projects report the opinion that many migrants leave the stream but these are constantly replaced by other poor, undereducated, minority group workers, and families who have acute health needs but poor understanding or acceptance of good health practices.

Health improvement in spite of high migrant population turnover could be facilitated if the program focused on the population reservoir from which migrants are drawn. In this reservoir, migrants merge with other low-income seasonal farmworkers. They live side by side, do the same work, live under the same conditions, and share the same social and economic handicaps.

Steps to Meet Migrant Health Program Goals

GOAL

Comprehensive health care with continuity as workers migrate.

STEPS TAKEN

Local planning has adapted services to migrants in 1 out of 3 migrant counties, and routine casefinding and emergency care systems have been established.

Communication systems are facilitating continuity of care as people move.

Aides (migrant and other) are supplementing scarce health manpower.

More local resources are being used as some communities start to accept responsibility.

Migrants are being helped to understand and accept responsibility.

STEPS NEEDED *

Expand geographic coverage, continuing to emphasize home-base areas.
Improve level and comprehensiveness of service.
Improve inter-area communication and coordination.
Reimburse hospitals for total costs.
Supplement scarce health manpower by use of aides and in other ways.
Strengthen relationships with other programs and use of their resources.
Intensify community education and orientation of health workers.
Involve growers, migrants, and other appropriate persons to greater extent.

* All would require renewal of legislation and additional funds to meet goal.

Meeting comprehensive health service goals will require funds more commensurate with the personal health service expenditures for the Nation as a whole. As other programs for the general population develop, they can be encouraged to take over some of the costs for services to migrants who are otherwise eligible. At the present time, however, there is little evidence of the readiness or, in many cases, the capacity of local communities and States to take full responsibility for health needs of migrants and other low-income seasonal farmworkers in the population reservoir from which migrants are drawn.

Steps to Meet Migrant Health Program Goals

GOAL

Healthful, safe environment wherever migrants live and work temporarily.

STEPS TAKEN

Sanitation services have been started in nearly 3 out of 5 migrant counties.

STEPS NEEDED *

Expand geographic coverage.

Assure safe water and waste disposal in every migrant housing area.

Add field sanitation services.

Improve system for financing housing and sanitation improvement.

Initiate safety program.

Improve work with growers, Employment Service, migrants, etc.

* All would require renewal of legislation and additional funds to meet goal.

Migrant Health Program Advantages

TO WORKERS AND THEIR FAMILIES

Better access to health care
Better health understanding and practice
Better health and longer life
Better earning power
Better acceptance in the community

TO GROWERS AND PROCESSORS

Healthy, productive workers
Less turnover in labor force
Money saving
Better community relationships

TO COMMUNITIES

Fewer health emergencies
Less tax drain
Increased migrant purchasing power

TO NATION

Healthy farm labor force
Higher level of productivity
Reduction of disability
Saving of lives

APPENDIX

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

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

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

Statement of Sen. Harrison A. Williams, Jr., of New Jersey on S. 2688, November 22, 1967, Congressional Record, p. S17010.

EXTENSION AND AMENDMENT OF CERTAIN PROVISIONS OF THE PUBLIC HEALTH SERVICE ACT FOR MIGRANT HEALTH SERVICES

Mr. WILLIAMS of New Jersey. Mr. President, I introduce, for appropriate reference today, a bill to extend and otherwise amend certain expiring provisions of the Public Health Service Act for migrant health services. Joining me in sponsoring this measure are Senator Case, Senator Clark, Senator Javits, Senator Kennedy of Massachusetts, Senator Kennedy of New York, Senator Morse, Senator Pell, and Senator Yarborough.

Mr. President, millions of Americans—migrant farmworkers and their families—traditionally have been excluded from community health services—excluded by distance, cost, their own lack of knowledge, their transiency, and community rejection. Migrants have less access to health care than other members of our population, although they generally have a greater need for health care. The migrant family's transient way of life aggravates the many basic health problems which are associated with their poverty, and poor living and working conditions. They live on the fringes of society, far removed from such fundamental community helath services as immunizations and obstetrical care.

The Migrant Health Act, enacted in 1962 as Public Law 89-692 with an appropriation ceiling of $3 million annually for a 3-year period, has started to change this picture, Because of its widely recognized success in upgrading the health of the migrant farm family, the act was extended by Public Law 89-109 for an additional 3 years with increasing appropriations. This extension carries the program through June 30, 1968.

We are far from providing each migrant the minimum standard of health most of us have; they need more than a get-well card. Extending the appropriation of the Migrant Health Act as I am proposing today will bring the Public Health Service programs to a more realistic level.

The Migrant Health Act which amends title III of the Public Health Service Act to authorize grants for improving domestic agricultural migratory workers' health services and conditions helps States and communities to muster the resources needed to extend their services to migrants.

Grants by the Public Health Service pay part of the cost of family clinics help in large labor camps at times when migrant workers and their families can use

the service without loss of time from work. Local physicians provide medical treatment for illness or injury at the family clinics. They also provide immunizations, screening for hidden disease, family planning services, and pre- and postnatal care. In addition, they supplement family clinic services by providing care in their own offices between clinic sessions.

Nurses assist the physicians in the clinics, and visit camps on a regular schedule to advise on health matters, identify health problems that require treatment, arrange for the patients to see project physicians, and see that patients understand and follow the doctor's instructions.

Migrant health grants also help to pay for dental care, health education, sanitation services, and other types of health services.

Programs under the act stress flexibility in the scheduling of services so as to make them available at times and places where migrants can effectively be reached. Night clinics are frequently held at points where migrant workers are concentrated and health aides work in migrant labor camps in order to bring service to people ill-accustomed to seeking and using medical care. Through these projects we are making progress in the health status, the personal health practices, and the environment of migrant workers and their families.

During the 1967 fiscal year, one-fourth of the Nation's migrants had access to project services for at least a brief period. Migrant workers and family members made more than 239,000 visits for medical or dental treatment. In addition, nurses made 125,000 visits to migrant families, for casefinding, followup, and health counseling; and sanitarians made 125,000 camp inspections.

However, the demand for migrant health services far exceeds the existing program's resources. Grant funds available for fiscal year 1968 were limited to $7.2 million, about $2 million less than the small authorization. Yet the needs for growth of existing projects—without adding a single new project anywhere in the country—came to more than $13 million. In other words, current needs already exceed available funds by approximately $6 million. New projects will increase the need beyond $6 million. In view of the lack of funds, the Public Health Service has had to notify new applicants that their projects cannot even be considered until additional funding is available.

For the first time in migrants' long history of neglect, the migrant health program provides a mechanism to bring this needy group higher on the priority list of States and communities. The program has demonstrated that the special incentive of project grants stimulates community planning and acceptance of responsibility. Many of the communities where migrants live and work temporarily are themselves below the national average in income. These communities desperately need the financial help which we have already generated.

The program is well started. Loss of the planning and organizational effort to deliver services to migrants would be unfortunate. Loss of services to the people would be tragic. Loss of momentum would be regrettable. To maintain the program's momentum and to realize its potential, it should now be extended. Moreover, the appropriation ceilings should be set at realistic levels that will enable the Public Health Service to increase the geographic coverage of project services; to strengthen and expand medical, dental, health education, and other project services; and to make grant assistance available for full reimbursement of hospital costs.

The Public Health Service has awarded grants to 31 projects serving migrants in 114 counties in 20 States by the end of the program's first operating year. Today, 115 projects provide migrants personal health care in 300 counties in 36 States and Puerto Rico.

Mr. President, I ask unanimous consent that the computation of migrant health projects, the services which they provide, and their directors listed by State be printed in the Record at this point in my remarks.

There being no objection, the computation was ordered to be printed in the Record, as follows:

APPENDIX B

[From the Department of Health, Education, and Welfare, Jan. 1, 1967]

PROJECTS RECEIVING MIGRANT HEALTH PROJECT GRANT ASSISTANCE

NOTE.—A. *Personal health services* usually include medical, nursing, health education and, in many cases, at least limited dental or other services; B. *Sanitation services* include housing, camp and field inspection and follow-up; plus work with owners and occupants of housing to improve maintenance of the general environment; C. *Statewide consultation* includes general assistance in program planning, development, and coordination.

ARIZONA

A, B—Catherine C. Le Seney, M.D., Director, Pinal County Migrant Health Project (MG–94), Pinal County Health Department, Post Office Box 807, Florence, Arizona.

C—Statewide consultation; personal health and sanitation services in counties without county-level projects: Robert C. Martens, Director, Arizona State Migrant Health Program (MG–111), State Department of Health, 1624 West Adams Street, Phoenix, Arizona 85007.

A, B—S. F. Farnsworth, M.D., Director, Maricopa County Migrant Family Health Clinic Project (MG–29), Maricopa County Health Department, 1825 East Roosevelt, Phoenix, Arizona 85006.

A, B—Frederick J. Brady, M.D., Director, Assistance to Pima County Migrants (MG–49), Pima County Health Department, 161 West Alameda Street, Tucson, Arizona.

A, B—Joseph Pinto, M.D., Director, Yuma County Migrant Family Health Clinic (MG–66), Yuma County Health Department, 145 Third Avenue, Yuma, Arizona.

ARKANSAS

A, B—Richard J. Brightwell, M.D., Director, Northwest Arkansas Migrant Committee Project, Washington County Public Health Center (MG–50), 34 West North Street, Fayetteville, Arkansas.

CALIFORNIA

Statewide consultation; personal health and sanitation services through county-level subprojects in cooperating counties: Robert Day, M.D., Director, Health Program for Farm Workers' Families, State Department of Public Health, 2151 Berkeley Way, Berkeley, California.

COLORADO

Statewide consultation and services to supplement those at county-level; personal health services through county-level subprojects in cooperating counties: Dr. Robert A. Downs, D.D.S., Director, State Migrant Plan for Public Health Service (MG–09), Colorado Department of Public Health, 4210 East 11th Avenue, Denver, Colorado 80220.

CONNECTICUT

B—Marvin L. Smith, Director, Improved Migrant Farm Labor Sanitation Program (MG–82), State Department of Health, Hartford, Connecticut 06115.

DELAWARE

A—Rev. Samuel A. Snyder, Jr., Director, Delaware Migrant Health Project (MG–83), Delaware State Council of Churches, 217 North Bradford Street, Dover, Delaware.

FLORIDA

Statewide consultation; personal health and sanitation services through county-level subprojects in cooperating counties: James E. Fulghum, M.D., Acting Director, Statewide Program of Health Services for (MG–18) Migrant Farm Workers and their Dependents, Florida State Board of Health, Post Office Box 210, Jacksonville, Florida 32201.

A, B—T.E. Cato, M.D., Director, Comprehensive Health Care Project for Migrant Farm Workers (MG–34), Dade County Health Department, 1350 Northwest 14th Street, Miami, Florida.

A, B—Donald N. Logsdon, M.D., Director, Improvement of Personal Health and Environmental Sanitation (MG–11), Palm Beach County Health Department, 826 Evernia Street, West Palm Beach, Florida.

IDAHO

B (primary focus)—F. O. Graeber, M.D., Director, Idaho's Migrant Health Services (MG–124), Idaho Department of Health, Statehouse, Boise, Idaho 83701.

ILLINOIS

Statewide consultation; personal health services in process of development in 3 counties: Donaldson F. Rawlings, M.D., Director, An Action Program for

Agricultural Migrant Workers and their Families (MG–105), Illinois Department of Public Health, Division of Preventive Medicine, Springfield, Illinois.

INDIANA

Statewide consultation; personal health and sanitation services in cooperating counties. Verne K. Harvey, Jr., M.D., Director, Health Services for Agricultural Migrant Workers and Families (MG–20), Indiana State Board of Health, 1330 West Michigan Street, Indianapolis, Indiana.

IOWA

A—Mrs. Richard E. Sandage, Director, Health Services for Migrant Families in the North Iowa Area (MG–116), Migrant Action Program, Inc., Box 717, Mason City, Iowa 50401.

A, B—Mr. Jerry Lange, Director, Muscatine Area Migrant Families Health Service (MG–23), Muscatine Migrant Committee, Post Office Box 683, Muscatine, Iowa 52761.

KANSAS

A, B—N. G. Walker, M.D., M.P.H., Director, Plan to Provide Health Services to Migrants, Kansas City-Wyandotte County Health Department (MG–74), 619 Ann Avenue, Kansas City, Kansas.

A, B—Patricia Schloesser, M.D., Director, Public Health Services to Kansas Migrants (MG–64), Kansas State Department of Health, Topeka, Kansas.

KENTUCKY

A, B—Jorge Deju, M.D., Director, Migrant Worker Health Project (MG–77), Kentucky State Department of Health, 275 East Main Street, Frankfort, Kentucky 40601.

LOUISIANA

A—Mr. Milburn Fletcher, Director, New and Improved Medical, Dental and Nursing Services to Migratory Workers and Families (MG–54), Health Subcommittee, Tangipahoa Migrant Committee, Box 257—Route 2, Ponchatoula, Louisiana.

MARYLAND

A—The Reverend Carroll L. Boyer, Director, Frederick County Migrant Health Project (MG–80), Frederick County Migrant Health Council, Inc., 1415 W. Seventh Street, Frederick, Maryland 21701.

MASSACHUSETTS

A—Leon Sternfeld, M.D., Director, Massachusetts Migrant Health Project (MG–68), Massachusetts Health Research Institute, Inc., 8 Ashburton Place, Boston, Massachusetts 02108.

MICHIGAN

B—Robert L. Maddex, Director, Improving Seasonal Labor Facilities to Benefit Migrant Health and Welfare (MG–76). Agricultural Engineering Department, Michigan State University, East Lansing, Michigan.

A (See MG–91)—Ralph Ten Have, M.D., Director, Cooperative Migrant Project (MG–31). Ottawa County Health Department, Grand Haven, Michigan.

B—Serves all counties in State housing migrants but lacking local sanitation project services: John E. Vogt, Director, Environmental Health Camp Sanitation Project For Migrant Worker and his Family (MG–91), Michigan Department of Health, 3500 North Logan, Lansing, Michigan.

Statewide consultation: Douglas H. Fryer, M.D., Director, Improvement and Expansion of Health Services to Migrant Agricultural Workers, and their Families (MG–30), Michigan Department of Health, 3500 North Logan, Lansing, Michigan

A, B—Gladys J. Kleinschmidt, M.D., Director, Migrant Family Health Clinic and Hospital Program (MG–131), Manistee-Mason District Health Department, 401 East Ludington Avenue, Ludington, Michigan 49431.

A, B—C. D. Barrett, Sr., M.D., M.P.H., Director, Migrant Family Health Services, Nursing, Sanitation and Dental (MG–79), Monroe County Health Department, Monroe, Michigan 48161.

A, B—Robert P. Locey, M.D., Director, Migrant Health Program (MG–107), Tri-County Associated Health Departments, 505 Pleasant Street, St. Joseph, Michigan.

MINNESOTA

A, B (in cooperating counties)—Statewide consultation: D. S. Fleming, M.D., Director, Migrant Labor Environmental Health, and Nursing Service and Health Education Project (MG–67) Minnesota Department of Health, University Campus Minneapolis, Minnesota 55440.

MISSOURI

A (limited)—David Ragan, Director, Family Health Education Services for Home Based Migrants (MG–104), Delmo Housing Corporation, Lilbourn, Missouri.

NEBRASKA

A, B (in one area of State)—T. R. Dappen, Director, Plan to Provide Health Education and Other Public Health Services for Migrant Families (MG–88), Nebraska State Department of Health, Capital Building, Post Office Box 94757, Lincoln, Nebraska 68509.

NEW JERSEY

A, B (in cooperating counties)—Statewide consultation: Thomas Gilbert, M.P.H., Director, Health Services for Migrant Agricultural Workers (MG–08), New Jersey State Department of Health, 129 East Hanover Street, Trenton, New Jersey 08625.

A, B—William P. Doherty, Director, Migrant Health Services, Cumberland County (MG–118), Board of Chosen Freeholders of Cumberland County, Cumberland County Court House, Bridgeton, New Jersey.

NEW MEXICO

A, B—Paul C. Cox, Director, Las Cruces Migrant Health Project (MG–15) Las Cruces Committee on Migrant Ministry, 1904 Idaho Avenue, Las Cruces, New Mexico.

A, B—Marion Hotopp, M.D., and Marion S. Morse, M.D., Codirectors, Migrant Health Project-Health Districts 1 and 5 (MG–134), New Mexico Department of Public Health, 408 Galisteo Street, Sante Fe, New Mexico 87501.

NEW YORK

A, B—G. Harold Warnock, M.D., M.P.H., Director, Cayuga County Migrant Health Services Program, Cayuga County Health Department (MG–106), 5 James Street, Box 219, Auburn, New York.

A, B—Bernard S. Bernstein, Director, Orange County Migrant Health Project (MG–135), Orange County Council of Community Services, Box 178, Goshen, New York.

A, B—Vernon B. Link, M.D., Director, New Paltz Migrant Health Project (MG–125), Ulster County Department of Health, 244 Fair Street, Kingston, New York 12401.

A, B—Michael D. Buscemi, M.D., Director, Suffolk County Migrant Health Project (MG–60), Suffolk County Department of Health, Suffolk County Center, Riverhead, Long Island, New York.

A—John A. Radebaugh, M.D., Director, Monroe County Migrant Project (MG–103), University of Rochester, River Campus Station, Rochester, New York 14627.

A, B—Evelyn F. H. Rogers, M.D., M.P.H., Director, Family Service Clinics (MG–38) Utica County Department of Health, Utica District Office, 1512 Genesee Street, Utica, New York 13502.

NEVADA

A—Otto Ravenholt, M.D., Director, Moapa Valley Migrant Health Program (MG–133), Clark County District Health Department, 625 Shadow Lane, Las Vegas, Nevada 89106.

NORTH CAROLINA

A—Caroline H. Callison, M.D., Director, Sampson Migrant Health Service Project (MG–122), Community Action Council, Inc., Clinton, North Carolina.

A, B—Isa C. Grant, M.D., Director, Albermarle Migrant Health Service Project (MG–57), District Health Service Project (MG–57), District Health Department, Elizabeth City, North Carolina.

A, B—Mrs. Frank R. Burson, Director, Henderson County Migrant Family Health Service (MG–28), Henderson County Migrant Council, Inc., 218 Fairground Avenue, Hendersonville, North Carolina.

A—Reverend Mr. Charles L. Kirby, Director, Carteret County Mobile Migrant Clinic (MG–27), Carteret County Migrant Committee, c/o First Presbyterian Church, Morehead City, North Carolina.

Statewide consultation; sanitation services in counties without sanitation services through local projects: W. Burns Jones, M.D., Director, Migrant Health Project (MG–56), North Carolina State Board of Health, Post Office Box 2091, Raleigh, North Carolina.

OHIO

A—Mrs. Ralph McFadden, Director, Migrant Health Study Project and Dental Care Program (MG–263), Hartville Migrant Council, 1812 Frazier Avenue Northwest, Canton, Ohio 44709.

B—(Statewide to supplement services of county-level projects): Ray B. Watts, Director, Environmental Health Project (Migrants), Ohio Department of Health, 450 East Town Street, Post Office Box 118, Columbus, Ohio.

Statewide consultation; direct services to supplement those through county-level projects: Miss Helen Massengale, Director, Health Aide, Nursing and Nutrition Consultation Project (MG–36), Ohio Department of Health, 450 East Town Street, Post Office Box 118, Columbus, Ohio.

A—(through cooperating county-level projects): William L. Babeaux, D.D.S., Director, A Program for Provision of Dental Services to Migrants (MG–86), Ohio Department of Health, 65 South Front Street, Columbus 15, Ohio.

A, B—William J. Boswell, M.D., Director, Migrant Health Clinics, Nursing and Sanitation Service Program (MG–21), Sandusky County-Freemont City General Health District, Fremont, Ohio.

A, B—Giles Wolverton, M.D., Director, Migrant Health Clinic and Nursing Services Project (MG–78), Darke County General Health District, Courthouse, Greenville, Ohio.

A—Rev. Robert Lamantia, Director, Ottawa County Migrant Family Health Service Clinic, Ottawa County Ministry to Migrants, 159 North Church Street, Oak Harbor, Ohio.

A—Milo B. Rice, M.D., Project Director, Migrant Labor Family Care Program (MG–61), Putnam County General Health District, Courthouse, Ottawa, Ohio.

A, B—Dorothy M. Van Ausdal, M.D., Director, Family Health Education Project for Migrants (MG–35), Lucas County Health Department, 416 North Erie Street, Toledo, Ohio 43624.

OKLAHOMA

A, B—Joan M. Levitt, M.D., Director, Project To Improve Health Conditions and Health Services to the Domestic Agricultural Migrants (MG–59), State Department of Health, 3400 North Eastern, Oklahoma City, Oklahoma.

OREGON

A, B—H. Grant Skinner, M.D., Director, Yamhill County Migrant Health Project (MG–63), Yamhill County Health Department, Courthouse, McMinnville, Oregon.

Statewide consultation; direct personal health and sanitation services and services through contacts in cooperating counties. Ralph R. Sullivan, M.D., Director, Clinic Care, Public Health Nursing and Sanitation Services to Migrant Farm Labor (MG–05), Oregon State Board of Health, 1400 Southwest Fifth Avenue, Portland, Oregon 97201.

PENNSYLVANIA

Statewide consultation; direct personal health and sanitation services in cooperating counties. A. L. Chapman, M.D., Director, Health and Medical Services for Migrants (MG–33), Pennsylvania Department of Health, Post Office Box 90, Harrisburg, Pennsylvania.

PUERTO RICO

A, B—Ruben Nazario, M.D., Director, Health Needs of Migrant Workers Project (MG–58), University of Puerto Rico, School of Medicine, San Juan, Puerto Rico 00905.

SOUTH CAROLINA

A, B—H. Parker Jones, M.D., Director, Comprehensive Health Program for Agricultural Migrants—Beaufort County (MG–121), Post Office Box 408,[1] Beaufort, South Carolina 29903.

A, B—E. Kenneth Aycock, M.D., Director, Health Services for Migratory Agricultural Workers and Their Families—Charleston County (MG–26), 334 Calhoun Street,[1] Charleston, South Carolina 29401.

TEXAS

A, B—Gonzalo V. Trevino, Director, Jim Wells County Migrant Health Project (MG–99), Jim Wells County Commissioners Court, Jim Wells County Court House, 200 North Almond Street, Alice, Texas 78332.

Statewide consultation provision of technical and professional assistance to special local projects in stablishing and maintaining their migrant programs.

A, B—Carl F. Moore, Jr., M.D., Director, Technical Assistance in Approaches to Health Problems Associated with Migratory Labor (MG–03), Texas State Department of Health, 1100 West 49th Street, Austin, Texas.

A, B—Jack F. Fox, M.D., and Harold R. Stevenson, M.D., Co-Directors, Greenbelt Medical Society Migrant Health Project (Childress and Hall Counties) (MG–109), Greenbelt Medical Society, 306 Third Northeast, Childress, Texas.

A, B—J. M. Barton, M.D., Director, La Salle County Migrant Health Project (MG–120), La Salle Court House, Center at Stewart Street, Cotulla, Texas 78014.

A, B—T. J. Taylor, Director, Crosby County Migrant Health Service Project (MG–108), Crosbyton Clinic Hospital, Post Office Box 248, Crosbyton, Texas.

A, B—B. Oliver Lewis, M.D., Director, Del Rio-Val Verde County Health Department Migrant Health Project (MG–128), Municipal Building, Del Rio, Texas.

A, B—R. D. Newman, Director, Castro County Migratory Health Project (MG–143), Castro County Commissioner's Court, Courthouse, Dimmitt, Texas.

A, B—Dr. John R. Copenhaver, M.D., Director, Hidalgo County Migrant Health Project (MG–117), Hidalgo County Health Department, Room 427, Courthouse, Edinburg, Texas.

A, B—L. W. Chilton, Jr., M.D., Director, Goliad County (Texas) Migrant Health Project (MG–114), Goliad Project for Handicapped Children, Box 53, Goliad, Texas 77963.

A, B—D. M. Shelby, M.D., Director, Gonzales County Migrant Health Project (MG–115), Gonzales County Medical Society, Gonzales, Texas 78629.

A, B—Jose L. Gonzalez, Director, Laredo-Webb County Migrant Family Health Project (MG–42), Laredo-Webb County Health Department, 400 Arkansas Avenue, Laredo, Texas.

A, B—David M. Cowgill, M.D., Director, Technical Assistance in Developing Techniques and Approaches to Health Problems Associated with Seasonal Farm Labor in Public Health Education, Sanitation, and Public Health Nursing, Countywide (MG–46), Lubbock City-County Health Department, 1202 Jarvis, Lubbock, Texas.

A, B—Carl P. Weidenbach, M.D., Director, Hale County Migrant Health Service (MG–37), Plainview-Hale County Health Department, 10th and Ash Streets, Plainview, Texas.

A—Mrs. Helen V. McMahan, Director, Yoakum County Migrant Health Service Project (MG–113), Yoakum County Commissioners, Yoakum County Courthouse, Box 456, Plains, Texas 79355.

A, B—Roy G. Reed, M.D., Director, Calhoun County Migrant Health Services Program (MG–95), Port Lavaca-Calhoun County Health Unit, 131 Hospital Street, Port Lavaca, Texas.

A, B—Dr. John R. Copenhaver, M.D., Director, Cameron County Migrant Health Project (MG–97), Cameron County Health Department, 186 North Sam Houston Boulevard, San Benito, Texas 78586.

A, B—Hon. Tom H. Neely, Director, Hudspeth County-Dell City Migrant, Hudspeth County Commissioners' Court, Hudspeth County Court House, Sierra Blanca, Texas.

A, B—H. A. Rickels, Director, Spur-Dickens County Health Service Project (MG–110), Spur City Aldermen, City, Post Office Box 356, Spur, Texas.

[1] Address of the project director is as shown. However, the sponsor in each case is South Carolina State Board of Health, J. Marion Sims Buildings, Columbia, S.C. 29201.

A, B—B. Oliver Lewis, M.D., Director, Southwestern Texas Health Department Migrant Project (MG–44), Southwestern Texas Health Department, Headquarters, Post Office Box 517, Uvalde, Texas.

A, B—Pedro Ramirez, Jr., Director, Zapata County Migrant Health Project (MG–100), Zapata County Commissioners' Court, Post Office Box 272, Zapata, Texas.

UTAH

A, B—Robert W. Sherwood, M.D., Director, Utah Migrant Health Service (MG–98) Utah State Department of Health, 44 Medical Drive, Salt Lake City, Utah, 84113.

VIRGINIA

A, B—J. B. Kenley, M.D., Director, Migrant Health Project—Virginia (MG–41), Division of Local Health Services, State Department of Health, Richmond, Virginia.

WASHINGTON

A, B—Dr. Phillip Jones, Director, Whatcom County Migrant Health Program (MG–132), Bellingham-Whatcom County District Health Department, 509 Girard Street, Bellingham, Washington 98225.

A, B—Ernest Kredel, M.D., Director, Health Services for Migrant Workers in Puyallup-Stuck Valley (MG–19), Tacoma-Pierce County Health Department, 649 County-City Building, Tacoma, Washington 98402.

WEST VIRGINIA

A, B—R. C. Hood, M.D., Director, Migrant Health Project (MG–123), Berkeley-Morgan County Health Department, 209 East King Street, Martinsburg, West Virginia.

WISCONSIN

A, B—Mrs. Clayton S. Mills, Director, Migrant Medical Aid Program (MG–75), Catholic Diocese of Madison, Guadalupe House, Elm Acre, Endeavor, Wisconsin 53939.

A—Mrs. Al Lambrecht, Director, St. Joseph Migrant Family Health Clinic (MG–129), St. Joseph Hospital, 707 South University Avenue, Beaver Dam, Wisconsin 53916.

A—Mrs. Mary Ann Minorik, Director, Waushara County (Wisconsin) Migrant Health Clinic (MG–130), Waushara County Committee for Economic Opportunity Box 310, Wautoma, Wisconsin.

Mr. WILLIAMS of New Jersey. Mr. President, at present only an estimated one-fourth of the total migrant population has access to Migrant Health Act project services. There is, therefore, an urgent need for increased Federal appropriations if we are to provide for the expansion of present project services to provide adequate coverage for the migrant worker and his family. Such expansion will add to the value of diagnostic service now offered and will make possible the funding of new projects where they are needed now. An increased number of health projects both in homebase areas and in communities along the migrant stream, are needed so that the migrant family will have the opportunity for uninterrupted clinical service.

The PRESIDING OFFICER. The bill will be received and appropriately referred.

The bill (S. 2688) to extend and otherwise amend certain expiring provisions of the Public Health Service Act for migrant health services, introduced by Mr. WILLIAMS of New Jersey (for himself and other Senators), was received, read twice by its title, and referred to the Committee on Labor and Public Welfare.

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