As early as 1909, President Theodore Roosevelt's Country Life Commission recommended efforts to improve migrant housing and to provide employment on an annual basis. Since then, national, State, regional, and local reports by voluntary organizations, public agencies, and temporary study or legislative committees have followed one another repetitiously.

The LaFollette Committee's hearings more than 30 years ago contain some of the material that was fictionalized in the "Grapes of Wrath". At that time, California was the scene of a strenuous effort to unionize farm workers. A few farm workers were killed and some were injured in the ensuing violence. The union organizers were driven off the farms and out of the labor camps.

About the same time, the Tolan Committee held hearings in various communities over the United States. Again and again witnesses reiterated the problems arising from transients' loss of residence status to qualify for medical care and other forms of local aid. The Public Health Service reported in 1941 on housing accommodations for migrants which fell far below minimal standards for health or decency, and on the higher rates of illness among transients of all types, as compared with residents of comparable income.

World War II awakened widespread concern over the need to provide an assured farm labor force so that farm production could be maintained. In the early 1940's, the Department of Agriculture, with nurses, physicians and other health workers assigned by the Public Health Service, undertook a farm labor health program under the War Food Administration. The program was conducted through 6

*Discussion led by Miss Helen Johnston, Deputy Chief, Migrant Health Section, DCWS, BSS, as part of [illegible]

regional organizations, each serving a migratory stream. Through these organizations the costs of medical, hospital, dental and nursing care were paid. When the war was over, all emergency legislation was abolished, and the agricultural workers' health associations were dissolved.

For a temporary period thereafter, a small Migrant Health Unit operated within the Bureau of State Services in the Public Health Service. The chief of the unit visited many States to talk with people about migrant health. At that time, the cry almost everywhere was "no money, no program."

To try to make the transition from the wartime program to peacetime normalcy a bit easier as far as migrants were concerned, a Federal interdepartmental committee was set up involving what was then the Federal Security Agency, the Department of Labor, the Department of Agricultural, and other Federal departments. Their report, "Migrant Labor...a human problem," published in 1947, is a concise statement of the migrant labor situation and recommendations for improvement. To a large extent, it is still current, although other reports have been published more recently.

There was little or no action following the 1947 Interdepartmental Committee's report. The President's Commission on Migratory Labor was then appointed, headed by Varden Fuller. This Commission held hearings in all parts of the country, got documentary evidence from various Federal and State agencies, and again compiled a very good report, one that is often quoted today.

About the same time, the Commission on the Health Needs of the Nation considered the health problems of migrants as a part of the total rural health problem of the United States. That Commission, too, briefly summarized the con-

The reports of these two Presidential Commissions stimulated public interest in the early 1950's. Senator Humphrey from Minnesota then held detailed hearings on migratory labor. The voluminous hearing reports are a very good documentation of the situation at that time. Senator Humphrey's objective in 1952 was to get a continuing committee established in government at the national level that could consider the multiple problems of migrants and develop means of dealing with them. As usual, nothing happened.

For a number of years, the Public Health Service had no single person or unit working on the subject of migrant health on a continuing basis. It kept receiving requests for information and assistance as a result of the interest of the Commission on Migratory Labor, the Commission on the Health Needs of the Nation, the Humphrey Committee, and other groups.

Various people in the Public Health Service were asked to respond to requests at various times. This became a concern to the Surgeon General, who decided to set up an Inter-Bureau Committee on Migrant Health. The inter-bureau committee included representatives of the Bureau of State Services, the Bureau of Medical Services, and the National Institutes of Health, as well as the Surgeon General's office. This Committee developed a report which suggested that a focal point unit be set up in the Bureau of State Services --- a point that would be visible and that could continue to deal with requests such as those that had been received by the Public Health Service in the past. The focal point unit would also be responsible for trying to involve all of the parts of the Public Health Service that needed to be involved in serving the health needs of this popu-

In 1954, Dr. Donald Harting, then assigned to the Children's Bureau as Medical Officer in Chicago, was brought back into the Public Health Service to head up what was called the Program Development Unit. One of the responsibilities of that unit was migrant labor. Dr. Harting and his staff (initially one person) started out by focusing chiefly on migrant labor because this was the problem on which they were then receiving the most communications and the most questions.

During the next few years, the program development unit took on a variety of responsibilities and went through several organizational changes. In 1961, the migrant health staff consisted of two persons and a secretary working more or less full-time as a focal point on migrant health under Dr. Harting's general direction. The staff worked with all parts of the Public Health Service through contact persons identified in each of the Divisions. They also tried to identify with someone in the Regional Offices. Because of the turnover in the Regional Office Public Health Service staff, however, it proved impossible to establish any continuing point of contact. They kept communications going through the Regional Health Directors, since they could not get identification of a person in each Region with enough continuity so that it was satisfactory either for the Central or for the Regional Offices.

Operating at this minimal level, the Migrant Health staff was able to "put out fires" and to keep the subject alive. They "put out fires" in terms of answering requests that came to the Public Health Service for information or for assistance. They participated in the Working Group and subcommittees of the President's Committee on Migratory Labor, formed late in 1954, and

In addition, they identified problems that were faced in States and localities on which health workers said they wanted help. The need for health records to assure greater continuity of care was found almost everywhere they went. Local nurses would say, "We can start immunizations, but we do not know what the people have had before. We don't know where they are going so we don't know where to make referrals".

Almost as soon as Dr. Harting arrived, the staff started working on health records. They worked with the States in trying to develop records that would be suitable for migrants to carry with them, that would transmit essential information.

Florida was one of the first States that was interested. The State of Florida developed a record which was quite large in size and contained a half-a-dozen different sheets, so that all members of one family had their records in one packaged. A large green plastic envelope was supposed to be the repository for these records.

The Public Health Service assigned a medical officer to Florida on the initial project to test this record. He made the physical examinations and filled in the records that were inserted into the family envelope. Then Florida hired a person who was supposed to try to contact health workers upstream and find out what they could offer to the people who were coming up. This was part of a project financed by the Children's Bureau to learn more about migrants and effective ways to work with them.

One thing learned from the project was that the crews are not very stable. As many as half of the members may change during a single year even

first year, went north to contact a few of the families who had the green envelope with the health records. He found that the records usually had disappeared. The plastic envelopes were being used for various necessary purposes and became known as the "diaper bag", a very practical use for many migrant families.

The Public Health Service learned something else from its cooperation in this project. Nurses and other health workers said they needed to know to whom to refer migrants when they went to other work localities. Accordingly, the migrant health staff prepared a directory listing the addresses and telephone numbers of health departments and of hospitals that were likely to take migrants on an emergency basis. The Children's Bureau printed the directory after the Public Health Service got information together from 100 counties on the East Coast, with the understanding that it was first to go out on a trial basis in mimeographed form. On this trial run, it was sent to all of the places on the East Coast from which the information was obtained.

In mimeographed form, the directory had a wonderful reception. People said, "How soon can we get copies?" So the migrant health staff got estimates on how many copies would be needed. About three years later, they were still getting requests. They then thought they should find out whether the directory needed to be revised and how useful it had been. One of the staff members of the unit visited sample communities on the East Coast. He talked with the various agencies -- Migrant Ministry, the Farm Labor Service, and the Health Department -- who had said that they needed

did not need this information. They knew where the people were going, and they would just send a note with the people and let them take it to the health department upstream. After this, the Unit went out of the directory business because it was too much effort for what was gained. It might have had some potential usefulness, but the staff was too limited to do much about it.

These general educational and informational activities by the Migrant Health Unit continued with various degrees of success until about 1½ years ago. At that time, Senator Harrison Williams of New Jersey started holding hearings on migrant labor in different parts of the United States. From the hearings, he reached the conclusion that a number of things needed to be done simultaneously. As a matter of strategy, he felt that it would be self-defeating to put all of these things into one legislative package because the package would be referred to numerous committees in Congress and would have little chance of being voted into legislation. So Williams introduced 11 separate bills including two on education, one for adults and one for children (these were later combined), and one each on health services, minimum wage, day care of children, better organization of farm placement procedures, child labor, and other subjects.

The health bill was the only one that survived the last session of Congress. Very briefly, as you know, it provides for an authorization of $3 million to the Public Health Service for both project grants and direct operations. The grants are for family service clinics and training of people who work in such clinics, and for other types of projects designed

to be concerned with the development of intra- and inter-state coordination.

Project grants represent quite a different approach from the one used during World War II, when there was almost complete Federal planning, organizing and financing of the agricultural workers' health program. Instead of a nationally developed and organized program, more or less superimposed on migrant areas, the Williams' approach starts from the other end. It provides for project grants which spread the basic planning and operating responsibility by providing a financial incentive to encourage States and localities to develop plans of their own in which they will have a vested interest, and in which they will also have a financial investment. The project grant is to pay for part of the cost, not the total cost, of a project.

The Bill as originally drafted had a provision for a national advisory group to the migrant health program. This provision was taken out by the House after Committee hearings. The House stated in its report that omission of the provision in the Bill did not mean that no committee could be formed. It simply meant that the Public Health Service already had the authority to appoint such a committee and did not need this specific legislative authorization.

The House Committee also imposed a three-year limitation. The House report stated that at the end of three years the program should be evaluated to see whether or not it meets a need and is adapted to the situation. There is no implication that the three-year limitation was imposed in order that the program would be automatically terminated at the end of three years.

This places a real responsibility on the Migrant Health Section to develop a program in the next 2½ years that will demonstrate that it does

to States and localities is sound and effective, and that State-Federal efforts to coordinate migrant health activities in different areas are actually productive.

The hearings on the health bill were held simultaneously with hearings on the education bill before the Senate Subcommittee on Migratory Labor, which is part of the Committee on Labor and Public Welfare. In the House, the Subcommittee on Health and Safety of the Interstate and Foreign Commerce Committee held hearings on the health bill.

In addition to the hearings and the reports of both Houses, two other documents which reveal Congressional intent are the Congressional Record for the day that the Bill came up on the Senate floor, and the Congressional Record for the day that the Bill came up on the House floor.

After all the discussion and struggle for more than a year and a half, when the Bill came up on the floor of the House, Congressmen on both sides of the aisle were vying with each other to be sure that they could get statements in the record in support of the bill. It had real bipartisan support.