TRI-COUNTY ASSOCIATED HEALTH DEPARTMENT

STATEMENT ON THE MIGRANT HEALTH PROGRAM

PREPARED FOR THE UNITED STATES SENATE

SUB-COMMITTEE ON MIGRATORY LABOR

December 13, 1967

Mr. Chairman, and members of the Subcommittee on Migrant Labor.

I am pleased to represent the Southwestern corner of Michigan here before you. If I were to mention the names of the towns in our Tri-county area, I doubt if you would recognize any of them, but there is no doubt in my mind that you have tasted our fruit or eaten our vegetables on several occasions during your lifetime. Our area is one of the most diversified crop areas in the country. The growing season opens with asparagus harvest in May and closes with grapes and apples in the late fall. Our particular agricultural industry requires large numbers of seasonal farm workers and thus we rely heavily on migrant laborers. The United States Department of Agriculture lists one of our counties, Berrien, as the nation's third ranking county in the utilization of migrant workers and another of our counties, Van Buren, in the eighth ranking position. Our peak utilization time is usually the middle of June when some 23,400 migrants are on hand,

19,800 of which are of working age. We generally maintain 6,000 to 10,000 seasonal workers during the eight months harvest period, which covers some twenty-five different crops. To house this large influx of people we have approximately 700 camps. When I first became Director of the Associated Health Departments in November of 1964, I was charged to do something about "the migrant problem." Being new to the area I did not know what this problem was; however, I soon discovered it was a situation of grave concern and one about which the community was quite ashamed. In fact, it may have been a very strong factor in finally organizing an approved health department in our area. In talking with doctors, dentists, hospital administrators, pastors, growers, city folk and heads of civic and voluntary agencies, I found the community divided in itself; each willing to blame the other and no one willing to take the leadership to solve this problem. This was not surprising in view of the magnitude of the situation. Because our communities are largely agricultural, the tax base was not felt to be sufficient to undertake a program that would meet the needs of these people. Our ratio of doctor to resident population is low and that same ratio for dentists is even lower. Paramedical manpower is at a premium. The many small political jurisdictions acted as so many fences, each enclosing a typical rural or semi-rural conservative people. Yet, the fact remained

that the migrant suffered during his tenure with us, and that unnecessarily high medical bills for migrant medical care were being paid by the tax payer due to lack of preventive care and of early care in cases of illness. Data obtained for the year 1964 showed that area hospitals had a loss of some $90,000 due to uncollected bills for migrant care. The Berrien County Welfare Department reported a cost of approximately $38,000 in 1964 for out-patient visits. Because the migrant worker waited until he was very sick before seeking help, it taxed our already hard-pressed medical man power.

The doctors were not so distressed at the additional hours they had to put in for migrant care but were more concerned about the follow-up on these people. They were concerned about the migrant's ability to obtain the prescribed medications that he should have and about the living conditions that their sick patients had to be returned to. Dentists in our area could handle only emergency care. No thought was given to the remedial aspect for migrants.

Organization was the only answer to the problem, and organization could only be attained through use of the Migrant Health Act of 1962. Since we were dealing with an interstate problem we felt it was a fair and just use of Federal funds. We were more than willing to put in our 25%. In fact, our contribution

greatly exceeded that amount. We knew that somehow we would have to develop some kind of educational program to stimulate migrants to seek care in the early stages of illness; that we would have to urge growers to afford adequate housing and a decent environment, to have safe water supplies, proper sewage disposal facilities and suitable provisions for personal hygiene, laundry and recreation; that we must somehow educate the migrant into the proper use of the facilities furnished by the grower; and that we must coordinate the health activities of official and voluntary agencies that were then providing assistance to migrants.

After months of planning and organization, we came up with a project that would cost approximately $1.28 per migrant per bi-weekly period for 13 bi-weekly periods. This is based on a bi-weekly average of 8,657 migrants from April 15th through October 15th. This is a very small amount, it is true. However, we tried to keep it practical in terms of the medical man-power we had available, our ability to recruit additional personnel, and the little experience that we had. We would have been content that first year with just holding our own while we were working out the bugs in the system and recruiting qualified personnel. However, our medical program was busy from the very outset. The number of out-patient visits supported in total or in part by the migrant health project for 1966 was 2,469.

The doctors working in the clinics were enthused about the quality and continuity of care given and the follow-up of these cases in the field. Administrators at the local hospitals noticed a decrease in hospitalization of migrant workers and members of their families. Physicians having offices nearest to the growing areas and physicians on call for hospital emergency rooms said that emergency calls for migrants had lessened considerably. Growers felt that lost time in the fields due to illness was lessened, giving him more man hours of work, and there were indications that many of the laborers would return next year because of the respect afforded them at the clinics. As one migrant put it, "This is the first time I felt treated like an equal human being." Our division of environmental health licensed 634 of the estimated 700 camps. Within this number of camps, 2108 item violations were noted and orders were issued for their correction. Because of the shortage of personnel, only 93 camps were visited a second time. Among these 93 camps, 224 violations were listed at the time of the initial visit. At the time of the second visit, 147 corrections had been made for a percentage correction of 65.6%, which was much better than the compliance rate for the State of Michigan as a whole, which was 39.9%. I believe that this in some way reflects the value of a complete project. If the grower sees that the doctors,

dentists, health department, civic and voluntary agencies are pitching in in one united effort, that he is more likely to go along. At the time of the initial camp visit for licensure inspection in 1967, the number of violations recorded dropped by 58% to 1224. By the end of the 1967 season our records show that over $110,000 had been put into improvements and new housing by the growers.

It is very difficult to compile, analyze and compare data regarding costs and losses for medical care on seasonal laborers due to several factors, including the present rapid rise in cost of medical care and differences in the definition of migrant laborers among medical facilities, in policies of welfare departments, and in the number of migrants from year to year. However, it is possible that any lowering of out-patient and in-patient costs for migrants could be related to the availability of facilities for early diagnosis and treatment of disease, to health education and to the improvement of housing. From the standpoint of out-patient cost, it is worth noting that in Berrien County the average cost per out-patient visit recorded by the Department of Social Services in 1964 was $12.78; while, in spite of rising medical costs, the cost per out-patient visit recorded by the migrant family clinics in 1966 averaged only $7.22.

For referrals made by project field personnel directly to private physician offices or hospital emergency room, the cost was $9.36.

Also worth noting is the comparative data on direct relief medical payments made by the Berrien County Welfare Department, both before and after the project started. In June, July and August of 1965, the cost was $6,488.34; in these same months of 1966 the cost was only $3,079.30, or a reduction of $3,409.04. The total cost per out-patient services during these same three months dropped from $9,898.32 in 1965 to $9,050.60 in 1966. Although the difference is not striking, it is a definite break in the trend of increasing medical care costs for the indigent. In terms of hospitalization during these same three months of 1965, $45,886.94 was spent on non-categorical hospitalization, which included migrant labor medical care costs. In 1966, the first year of the project, the cost for non-categorical hospitalization was only $39,521.95, or, $6,345.00 less. However, if you compare the first five months of 1965 and 1966 for non-categorical hospitalization, 1966 shows an increase in cost over 1965 by almost $30,000. Thus, the cost for non-categorical hospitalization had actually taken a sudden change from an increasing to a decreasing trend during the time the family health clinics for migrants were operating.

Such figures as the preceding ones, which are used as indicies to evaluate the progress of the migrant health program, cannot give the entire picture; yet, they do give an indication that preventative care and early care is less costly. Such early care is afforded the migrant through the program developed by our communities as a result of the Migrant Health Act of 1962. The savings in terms of out-patient care and hospitalization in no way make up for the total cost of the project, but this is more than made up by a more knowledgeable migrant, a healthier migrant, and one who is more productive and who is less of a burden on the tax payer. The value is immeasurable in terms of the migrant's dignity.

One of the greatest fears at the beginning of the project was that migrants who had higher than average capabilities for that class of people and who were more stable from year to year than most seasonal workers, would abandon paying for their own care as they had done in the past. This proved to be untrue. Private physicians have reported that through the first and second years of the project those migrants who had been previous patients and were paying for their care were continuing to come to their office and were paying their bills.

Our report for 1967 is being compiled but is not yet completed; however, from observation, we know that our program has improved significantly. This year we had an outbreak of

diptheria which we were able to handle efficiently and effectively. After the situation was cleared up, I shuddered when I reflected on what we would have done had we not had the migrant health project.

Although we have made a great deal of progress I am sure that you realize how difficult it is to develop something of this proportion in a two-year period of time. We had hoped to be sufficiently organized by the time our project ran out on June 30, 1969. Even then we will need some continuing financial support. To say, or given the impression, that our current program will be sufficient at the end of three years would be misleading. We still would not have sufficient environmentalists to inspect all camps at least twice during the season. We still would not have sufficient nurses and health education aides to make the meaningful personal contacts necessary in many problem areas. We still would have difficulty in bringing remedial dental care to just the migrant children involved, and routine screening procedures for vision, hearing, tuberculosis and other chronic diseases would be at the most, imperfect.

In our experience, it would seem desirable not only to continue the Migrant Health Act, but to furnish additional matching funds to increase the small expenditure of $1.28 per migrant per bi-weekly period. We have some very conservative people in our area, but as a whole they see the value of the money that has been spent and are for raising the amount of money that will do the job properly.

In my opinion, there is still much to be done on a Federal level. At the present time most family health clinics within any particular migrant stream operate independently of one another. Hopefully, a cohesiveness of such clinics can be brought about to produce increasing continuity of care. The effectiveness of the entire program could also be enhanced if migrants could be evaluated, preventive measures begun and needed consultation given before leaving their home base.

We are now faced with the threat that the Migrant Health Act will no longer exist after June 30th of 1968. As I understand it, one of the reasons for the discontinuation is to make more money available for the Comprehensive Health Planning Act. In effect, this would mean diluting migrant health monies over a much broader population. This may be the right and just thing to do for categories of a universal nature such as heart, cancer, stroke, diabetes, tuberculosis and others which are common to all localities. However, the migrant situation is not a universal one. It is a problem experienced by relatively few localities. These localities by their nature are rural and do not have the resources to meet the needs of the migrant worker and his family.

If you throw migrant health monies into a general pot with these other disease categories you are treating the migrant as a disease entity which indeed he is not. Although

he may speak another language or be of a minority group, he is a human being deserving of respect. He is necessary to the economy and productivity of this nation. Although he is an American, he is, in many instances, an unfortunate captive of his work because of his education, background and capabilities.

The migrant health program is just not a mechanism to provide immediate, acute treatment and improvement of living conditions. It is designed with a lasting effect in mind, to educate and to promote and maintain the health of an underprivileged group of Americans who must eventually take their place in the mainstream of American life. This will come as their education and social acceptance improves and as they are replaced by mechanization.

I hope you do not see our request to continue the Migrant Health Act as a selfish move. For we are interested in more than the growing of fruits and vegetables. We would like to see America grow in a manner commensurate with its very honorable preamble.

TABLE I

BIWEEKLY NUMBERS OF SEASONAL AGRICULTURAL WORKERS BY LOCATION OF ORIGIN
Berrien, Cass, Van Buren Counties - 1966

DATE	LOCAL	INTRASTATE MIGRATORY	INTERSTATE MIGRATORY	TOTAL
4/15/66	750	75	225	1,050
4/30	1,250	75	475	1,800
5/15	1,200	60	740	2,000
5/31	2,100	200	2,900	5,200
6/15	2,050	375	4,200	6,625
6/30	4,290	1,125	17,985	23,400
7/15	3,245	430	10,925	14,600
7/31	2,810	665	7,675	11,150
8/15	2,765	705	7,345	10,815
8/31	3,155	360	8,010	11,525
9/15	2,880	420	6,905	10,205
9/30	2,555	195	5,285	8,035
10/15	2,260	165	3,710	6,135
Biweekly Average	2,408	373	5,875	8,657
Weekly Average	93.6	14	226	4,326

Source and Movement of Seasonal Agricultural Laborers

According to data gathered by the State Health Deparcment for the year 1966, the following states supplied seasonal agricultural labor to the state of Michigan in the percentages given as follows:

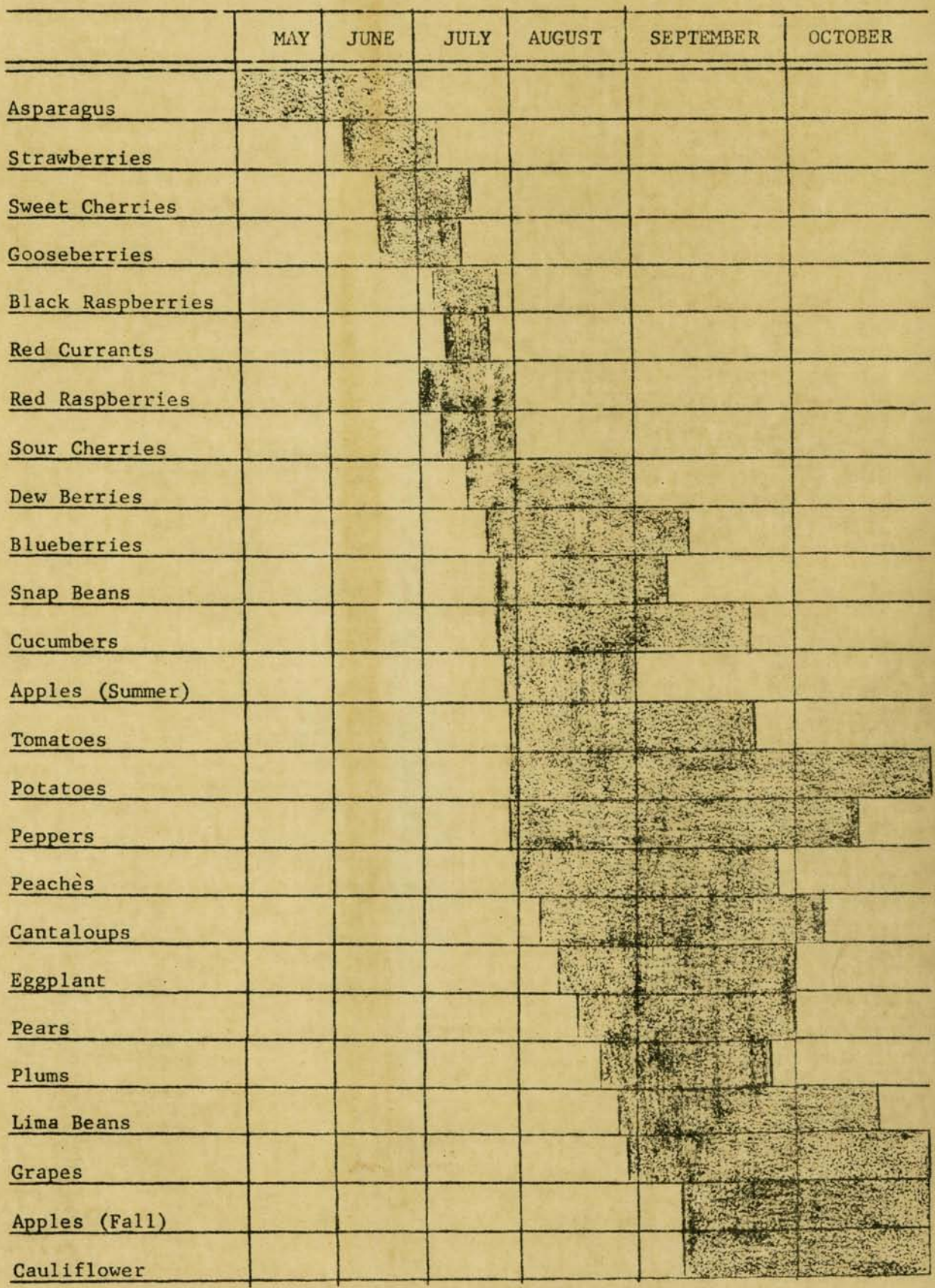
Texas	69.8%	Minnesota	1.1%
Florida	11.4%	Arkansas	1.0%
Louisiana	4.2%	Other States	3.9%
Missouri	3.3%	Michigan	3.8%
Mississippi	1.5%		

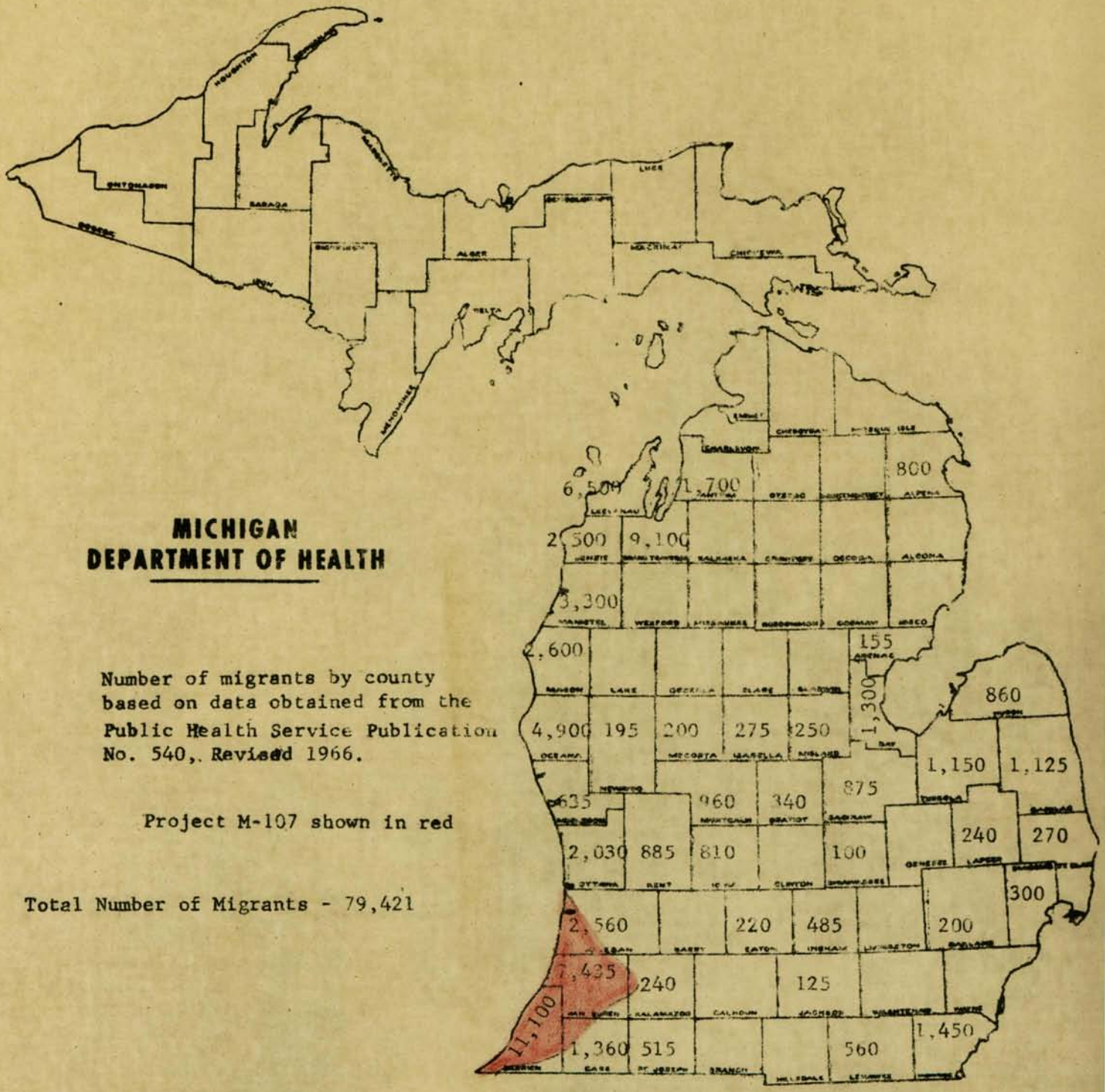
Based on Michigan Employment Security Commission data shown in Table I, the composition of all seasonal farm workers on the basis of the biweekly average was as follows:

Local	27.8%
Intrastate	4.4%
Interstate	67.8%

EXHIBIT I

HARVEST TIME FOR FRUITS AND VEGETABLES GROWN IN SOUTHWESTERN MICHIGAN





MICHIGAN DEPARTMENT OF HEALTH

Number of migrants by county based on data obtained from the Public Health Service Publication No. 540,. Revised 1966.

Project M-107 shown in red

Total Number of Migrants - 79,421

MIGRANT LABOR UTILIZATION

TEN TOP RANKING COUNTIES* IN THE UNITED STATES
1966

COUNTY	STATE	ESTIMATED PEAK POPULATION	
		Number of Workers	Number of Persons
Fresno	California	22,000	27,500
Palm Beach	Florida	16,757	27,928
Berrien	Michigan	11,100	12,500
Grand Traverse	Michigan	9,100	10,230
San Joaquin	California	9,000	11,250
Santa Clara	California	8,200	10,350
Marion	Oregon	7,500	10,700
Van Buren	Michigan	7,435	8,360
Yolo	California	6,930	8,662
Riverside	California	5,960	6,810

* According to a joint report; United States Department of Labor, Bureau of Employment Security and the United States Health Service.

MIGRANT HOSPITALITY CENTER...

Site for registration and health education Sodus Clinic

KEELER SCHOOL...

Facility which housed migrant clinic and educational program

NORTHRUP LODGE...

Site for registration at Lacota

TABLE II

MAN HOURS SPENT AT MIGRANT HEALTH CLINICS
AT LACOTA, SODUS, KEELER BY TYPE OF PERSONNEL
1966

Physicians	222
Nurses	536
Laboratory Technicians	215
Clerical	264
Health Aides	184
Volunteers	584
All Personnel	2,005

TABLE IV

PATIENT VISITS BY AGE AND SEX - MIGRANT HEALTH CLINICS
Lacota, Sodus and Keeler - 1966

Age Group	Sex	No. First Visits	%	No. Revisits	%	Total Visits
0 - 1	M	66	12.7	33	13.8	99
	F	56	7.3	23	7.0	79
1 - 4	M	96	18.5	35	14.6	131
	F	108	14.1	50	15.4	158
5 - 14	M	150	29.0	70	29.2	220
	F	189	24.7	70	21.6	259
15 - 24	M	82	15.8	24	10.0	106
	F	160	20.9	56	17.2	216
25 - 44	M	80	15.4	41	17.1	121
	F	183	23.9	91	28.0	274
45 - 64	M	36	6.9	32	13.3	68
	F	68	8.9	34	10.4	102
65 +	M	7	1.3	4	1.6	11
	F	0	0.0	0	0.0	0
Unknown		16		19		35
TOTAL All Ages	M	517	39.9	239	41.1	756
	F	764	59.0	324	55.6	1,088
	U	16	1.7	19	3.3	35

TABLE III

OUTPATIENT VISITS SUPPORTED IN TOTAL OR IN PART
BY THE MIGRANT HEALTH PROJECT
1966

FACILITY	FIRST VISIT	REVISITS	TOTAL VISITS
Keeler Migrant Health Clinic	727	434	1,161
Sodus Migrant Health Clinic	489	118	607
Lacota Migrant Health Clinic	81	30	111
Berrien General Hospital	233	158	391
Watervliet Community Hospital	32	5	37
Mercy Hospital	7	0	7
Memorial Hospital	2	1	3
Pawating Hospital	1	0	1
South Haven Community Hospital	9	1	10
Lakeview Hospital	9	0	9
Lee Memorial Hospital	70	0	70
Private Physicians	35	16	51
Dentists	6	5	11
TOTAL	1,701	768	2,469

HEALTH AIDE...

¿ Que es el problema?

MOBILE CLINIC...

a roving ambassador

DENTIST...

Mobile Too!

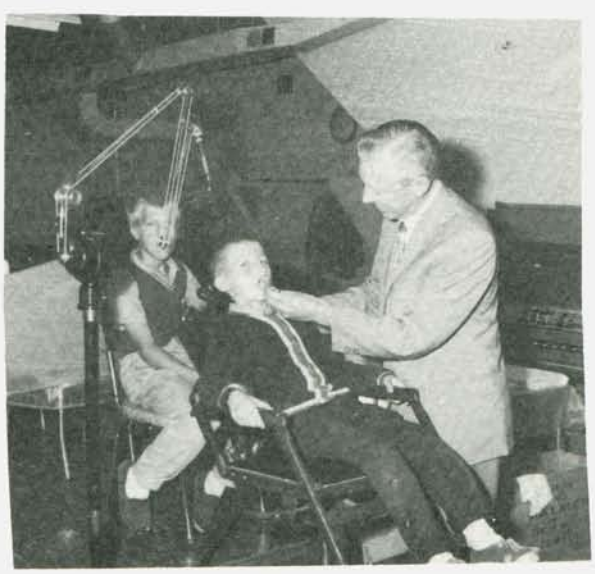


TABLE V

TYPES OF ILLNESS SEEN IN CLINICS BY AGE GROUPS
MIGRANT HEALTH CLINICS
Keeler, Sodus, Lacota - 1966

	0-1	1-4	5-14	15-24	25-44	45-64	65+	Unk.	Total
Infectious & Parasitic Diseases	4	26	25	9	11	0	0	0	75
Neoplasma	1	0	0	5	1	0	0	0	7
Allergic, Metabolic & Nutritional Disease	3	0	2	9	7	10	0	0	31
Diseases of Blood	0	3	1	1	1	0	0	0	6
Mental & Personality Disorder	0	0	0	0	0	0	0	0	0
Diseases of the Nervous System	16	21	56	15	16	9	0	3	136
Diseases of the Circulatory System	0	3	3	4	18	14	0	0	42
Diseases of the Respiratory System	42	71	137	58	85	47	1	3	444
Diseases of the Digestive System	28	45	15	6	20	20	1	0	135
Diseases of the Genitourinary System	0	0	9	40	26	10	0	1	86
Deliveries, Pregnancy	0	0	10	36	30	0	0	0	76
Diseases of the Skin	9	29	63	21	16	6	1	7	152
Diseases of the Bone	0	0	3	1	8	10	1	0	23
Certain Disease of Early Infancy	9	2	1	1	1	0	0	0	14
Ill-defined conditions Symptoms & Senility	25	12	25	27	48	26	2	2	167
Injuries, Accidents & External Causes	2	12	50	32	33	6	1	6	142
Special Conditions & Exams; No Sickness	9	4	27	28	31	6	0	2	107

TABLE VII

LABORATORY TESTS PERFORMED DURING
MIGRANT HEALTH CLINICS
Keeler, Sodus, Lacota - 1966

TYPE OF TEST	KEELER	SODUS	LACOTA	TOTAL
Serology	59	27	1	87
Urinalysis	91	28	4	123
Hemoglobin	75	12	7	94
Hematocrit	67	11	4	82
WBC Count	63	12	1	76
Differential	59	12	1	72
Culture	105	0	4	109
Sensitivity	42	0	0	42
Blood Sugar	9	0	0	9
Parasites	7	4	2	13
Gram Stains	2	0	0	2
Uric Acid	2	0	0	2
TOTAL	581	106	24	711

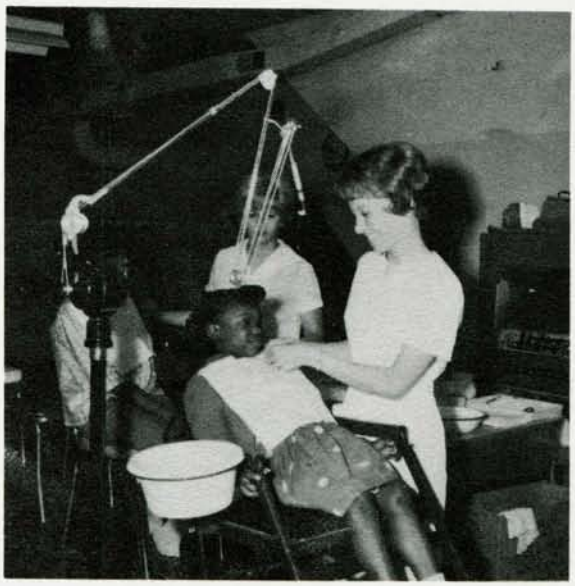
TABLE VIII

DRUGS DISPENSED BY AGE GROUPS
MIGRANT HEALTH CLINICS
Keeler, Sodus, Lacota - 1966

	0-1	1-4	5-14	15-24	25-44	45-64	65+	Unk.	Total
Analgesics & Antipyretics	15	19	30	39	67	36	4	2	212
Anthelmintics	4	6	2	0	0	0	0	0	12
Antibiotics	82	90	229	107	119	62	5	3	697
Antihistamines	11	9	28	19	27	5	1	3	103
Relaxants	3	3	1	4	17	8	1	3	40
Digestants	20	26	13	9	14	2	1	0	85
Expectorants	8	19	25	11	18	6	0	1	88
Vitamins	5	10	14	5	11	5	0	0	50
Hormones	0	0	2	1	3	1	0	0	7
Narcotics	0	3	0	1	2	0	0	0	6
Other Anti-Infective	1	24	21	4	5	0	0	0	55
Other	5	10	15	10	23	27	0	2	92

PEDIATRICIAN...

draws wonderment



DENTAL HYGIENIST...

draws a smile

LABORATORY TECHNICIAN...

draws blood

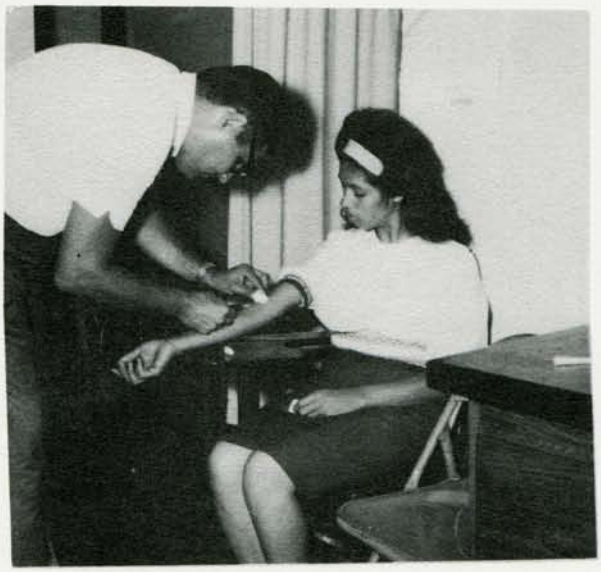


TABLE IX

TOPICAL FLUORIDE TREATMENTS
Covert, Berrien Springs & Sodus
Migrant Health Program
1966

LOCATION	TOTAL NUMBER CHILDREN	PERCENT RECEIVING APPLICATIONS				NUMBER COMPLETED
		FIRST	SECOND	THIRD	FOURTH	
Covert	46	100	100	89.1	89.1	41
Berrien Springs	88	100	100	94.3	94.3	83
Sodus	78	100	100	69.2	69.2	54
TOTAL All Locations	212	100	100	83.9	83.9	178

TABLE X

REMEDIAL DENTAL CARE
Referrals from Covert, Berrien Springs & Sodus
Migrant Health Program
1966

REFERRAL LOCATION	NUMBER OF REFERRALS	NUMBER RESTORATIONS	NUMBER EXTRACTIONS	NUMBER OTHER TREATMENTS	COMPLETED CASES
Covert	6	6	4	8	5
Berrien Springs	3	6	0	0	1
Sodus	13	37	8	6	13
TOTAL All Locations	22	49	12	14	19

TABLE XII

A COMPARISON OF THE LIVING UNIT TYPES IN BERRIEN - CASS - VAN BUREN COUNTIES

TYPE OF FACILITY	NUMBER OF UNITS			PERCENTAGE BY UNIT TYPE		
	Berrien	Cass	Van Buren	Berrien	Cass	Van Buren
Motel	57	2	44	10.8	6.0	12.2
Cabin	325	17	224	61.7	51.5	61.8
Barracks	15	2	10	2.9	6.0	2.8
Multi-Purpose	89	4	46	16.8	12.2	12.7
Other	41	8	38	7.8	24.3	10.5
TOTAL	527	33	362	100.0	100.0	100.0

TABLE XIII

COMPARISON OF CAMP CAPACITY RANGES IN THE TRI-COUNTY AREA MICHIGAN REPORTS - 1966

CAPACITY RANGE IN WORKERS PER CAMP	NUMBER OF CAMPS		PERCENT	
	Michigan	Tri-County	Michigan	Tri-County
5 - 24	1217	281	47.3	44.3
25 - 49	827	205	32.1	32.3
50 - 99	392	102	15.2	16.2
100+	138	46	5.4	7.2
TOTAL	2574	634	100.0	100.0

TABLE XV

DISTRIBUTION OF HOUSED AGRICULTURAL WORKERS BY COUNTY TRI-COUNTY AREA - 1966

COUNTY	NO. OF CAMPS	TOTAL WORKER CAPACITY IN LICENSED CAMPS	PERCENT OF AREA WORKERS IN LICENSED CAMPS
Berrien	359	9,461	38.8
Cass	23	945	3.9
Van Buren	252	13,986	57.3
TOTAL	634	24,392	100.0

TABLE XVI

SOURCE OF WATER SUPPLIES SERVING TRI-COUNTY CAMPS
COMPARED WITH MICHIGAN EXPERIENCE

WATER SOURCE	MICHIGAN		TRI-COUNTY	
	Number	Percent	Number	Percent
Municipal	73	2.8	15	2.4
Private	2496	97.0	616	97.0
Both	5	0.2	3	0.6
TOTAL	2574	100.0	634	100.0

TABLE XVIII

TYPE OF SEWAGE DISPOSAL SYSTEMS UTILIZED FOR TRI-COUNTY CAMPS
COMPARED WITH MICHIGAN

TYPE OF SYSTEM	MICHIGAN		TRI-COUNTY	
	Number	Percent	Number	Percent
Municipal	30	1.2	13	2.0
Private	2538	98.6	620	97.8
Both	6	0.2	1	0.2
TOTAL	2574	100.0	634	100.0

TABLE XX

COMPARISON OF COOKING FACILITIES IN TRI-COUNTY AREA
WITH MICHIGAN EXPERIENCE

TYPE OF FACILITY	MICHIGAN		TRI-COUNTY	
	Number	Percent	Number	Percent
Central	8	3.4	5	0.8
Individual	2454	95.3	623	98.3
Both	33	1.3	6	0.9
TOTAL	2495	100.0	634	100.0

TABLE XXII

COMPARISON OF RULE VIOLATIONS AND NUMBER OF ITEM VIOLATIONS
TRI-COUNTY - 1966

RULE		RULE VIOLATIONS	ITEM/RULE RATIO	ITEM VIOLATIONS
5	Camp Maintenance	36	1.0	36
6	Water Supply	163	1.3	201
6a	Camp Area	42	1.0	44
7	Shelters	46	1.3	60
8	Fire Safety	182	1.7	301
9	Lighting & Ventilation	233	2.0	474
10	Heating	7	1.9	13
11	Cooking & Eating	69	1.0	69
12	Bathing Facilities	147	1.1	164
13	Toilet Facilities	264	1.6	415
14	Laundry Facilities	3	1.0	3
15	Sewage Disposal	32	1.0	32
15a	Refuse & Garbage	234	1.3	296
TOTAL VIOLATIONS		1458	1.4	2108

TABLE XXIII

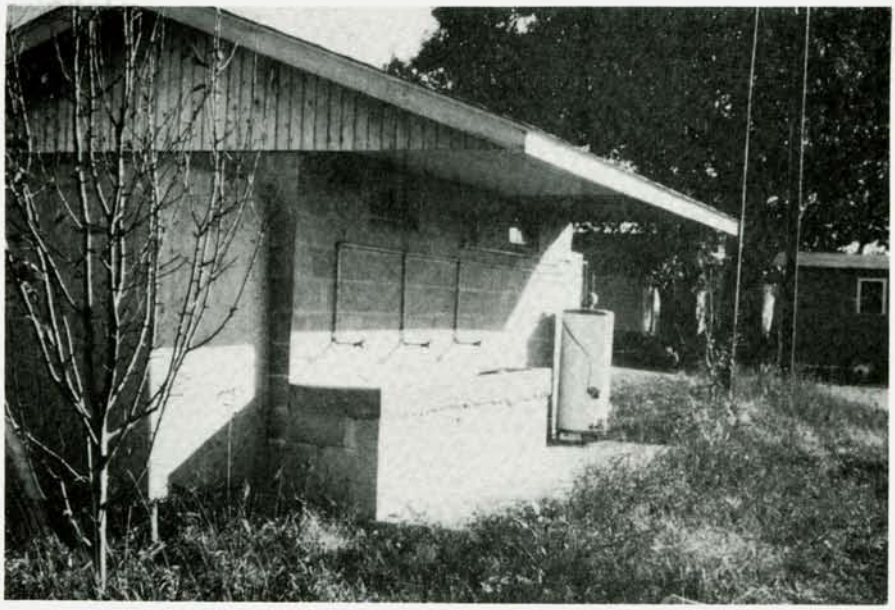
COMPARISON OF CAMP LICENSES ISSUED BY TYPE & BY INSPECTIONAL AGENCY

TYPE OF LICENSE	TOTAL NUMBER	NO. INSPECTED BY STATE H.D.	NO. INSPECTED BY LOCAL H.D.
Full	559	187	372
Provisional	70	20	50
Temporary	5	2	3
TOTAL	634	209	425

TABLE XXIV

SUMMARY OF FINDINGS OF RULE VIOLATIONS & CORRECTIONS
ON 93 CAMPS HAVING TWO OR MORE INSPECTIONS
TRI-COUNTY AREA - 1966

AREA	NO. CAMPS REVISITED	NO. INITIAL VIOLATIONS	NO. OF CORRECTIONS	NO. OF NEW VIOLATIONS
Berrien	62	153	98	16
Cass	1	5	5	0
Van Buren	30	66	44	22
TRI-COUNTY TOTAL	93	224	147	38



SHOWER FACILITY...

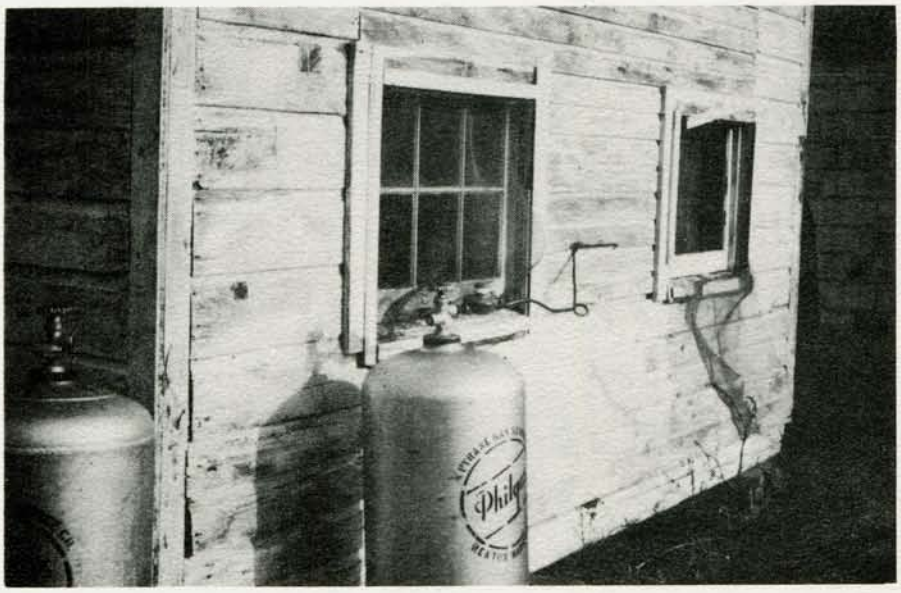
With outside hand washing basins.

The luxury of hot water!

. . . FOR BETTER . . .

EXCELLENT HOUSING...

Each unit has its own privy.



ACCIDENTS WILL HAPPEN...

Gas check-off valve placed too close to window.

Poorly maintained screening.

. . . OR FOR WORSE . . .

NO COMMENT!

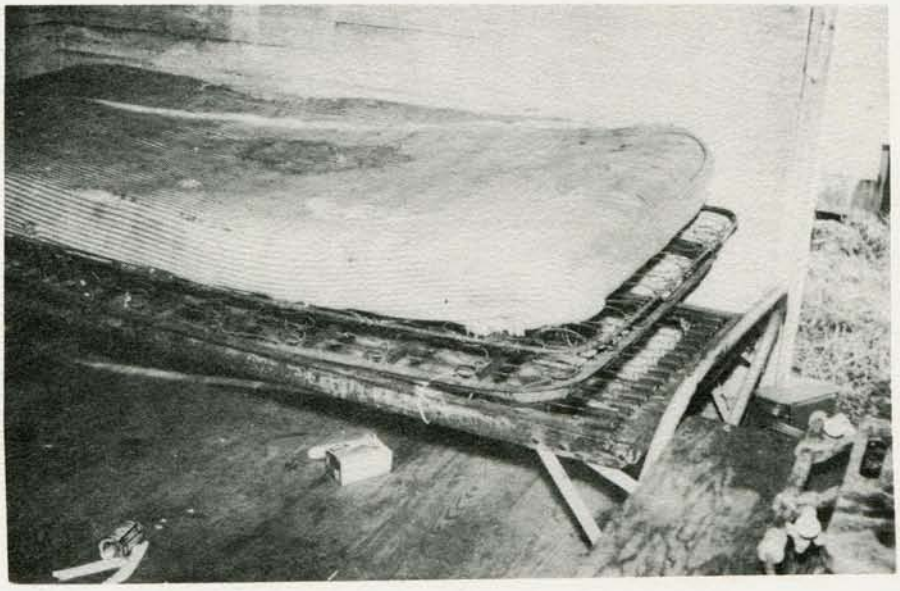


TABLE XXV

CORRECTION RATE FOR RULE VIOLATIONS FOR CAMPS HAVING TWO OR MORE INSPECTIONS
TRI-COUNTY - 1966

AREA	VIOLATIONS	CORRECTIONS	PERCENT CORRECTIONS
Berrien	153	98	64.1%
Cass	5	5	100.0%
Van Buren	66	44	66.6%
TRI-COUNTY TOTAL	224	147	65.6%

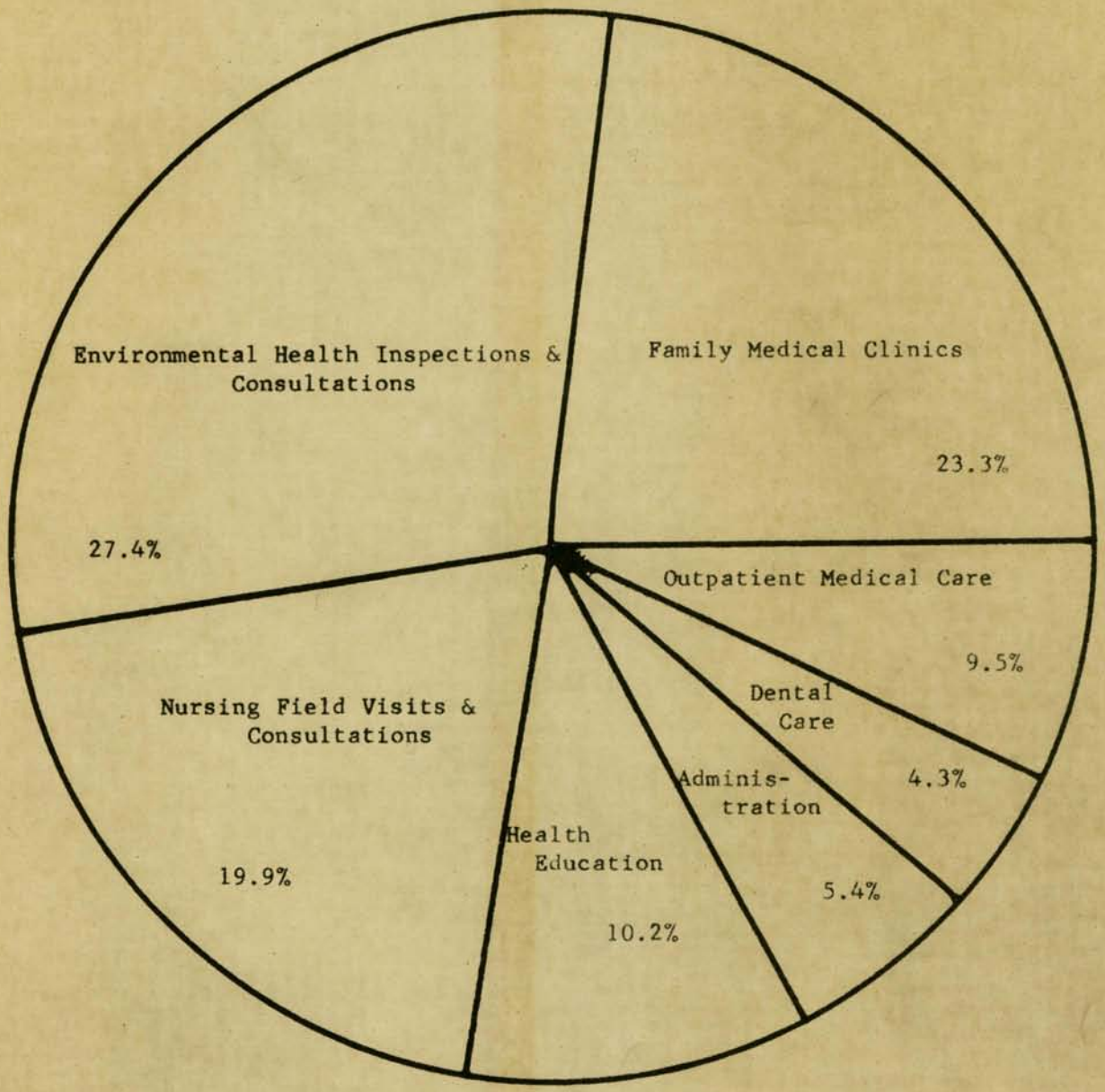
TABLE XXVI

FREQUENCY OF RULE VIOLATIONS BY COUNTY FOR TRI-COUNTY AREA - 1966

		VIOLATIONS EXPRESSED IN PERCENT OF CAMPS INSPECTED			
	RULE	Tri-County	Berrien	Cass	Van Buren
5	Camp Maintenance	5.7%	5.5%	0%	6.4%
6	Water Supply	25.7	30.1	17.4	17.1
6a	Camp Area	7.2	10.0	4.4	2.0
7	Shelter	7.6	9.3	4.3	5.5
8	Fire Safety	28.8	30.2	17.4	24.0
9	Lighting & Ventilation	36.8	47.4	13.0	22.6
10	Heating	1.1	2.0	.0	1.3
11	Cooking & Eating	10.9	14.6	4.3	9.5
12	Bathing Facilities	23.2	6.2	52.1	51.7
13	Toilet Facilities	41.3	51.8	13.0	31.7
14	Laundry Facilities	0.5	0.8	.0	0.4
15	Sewage Disposal	5.1	6.9	.0	2.8
15a	Garbage & Refuse Disposal	36.8	46.0	13.0	26.2

PERCENTAGE DISTRIBUTION OF EXPENDITURES

MIGRANT HEALTH PROGRAM - 1966



INFORMATION AVAILABLE ON ADMISSIONS AND COST FOR MIGRANT LABOR

HOSPITALIZATION PRIOR TO START OF MIGRANT HEALTH PROGRAM

HOSPITAL	TIME INTERVAL	NUMBER OF ADMISSIONS	GROSS COST	PAID BY MIGRANT	PAID BY INSURANCE	UNCOLLECTED
South Haven	8/64-8/65	96	12,253	1,413		10,840
Lakeview	8/64-8/65	114	7,541	1,240	769	5,530
Lee Memorial	1/65-9/65	10				1,238
Pawating	Annually	8				1,000(est)
Mercy	1/65-9/65	32				4,000(est)
Watervliet	Annually	33				4,500(est)
Memorial	Annually	8				1,000(est)
Berrien General	4/64-10/64	420	58,880	1,200		57,680
						88,288