DOCUMENT RESUME

ED 118 334 RC 009 009

TITLE Health Services for Domestic Agricultural Workers, 1972: S. 3762 -- To Extend the Program for Health Services for Domestic Agricultural Migrant Workers. Joint Hearing before the Subcommittee on Health and the Subcommittee on Migratory Labor of the Committee on Labor and Public Welfare, United States Senate, 92d Congress, 2d Session, August 1, 1972.

INSTITUTION Congress of the U.S., Washington, D.C. Senate Committee on Labor and Public Welfare.

PUB DATE 1 Aug 72

NOTE 242p.; Not available in hard copy due to marginal legibility of original document

EDRS PRICE MF-$0.83 Plus Postage. HC Not Available from EDRS.

DESCRIPTORS Agricultural Laborers; Delivery Systems; *Federal Legislation; Federal Programs; Health Needs; Medical Services; *Migrant Health Services; *Migrant Workers; *Program Budgeting; *Resource Allocations; Rural Population

ABSTRACT

On August 1, 1972, the Subcommittee heard testimony on bill S. 3762 which would extend the program for health services for domestic agricultural migrant workers. The bill would extend the migrant health program for 5 years, with $100 million authorized for fiscal year 1973 and a $25 million increase for each of the following years. S. 3762 represented a first attempt to bring the funding level for migrant health care services into some appropriate relationship to the documented level of need. Among the witnesses were the Assistant Secretary for Health and Scientific Affairs and representatives from the Community Health Service, the Hidalgo-Starr Catholic Charities (San Juan, Texas), the Texas Rural Legal Aid, the Orange Cove (California) Clinica de Salubridad, the Clinica de Salubridad de Campesinos, the Yakima Valley Clinic (Grandview, Washington), and the Mirgrant Legal Action Program, Inc. (Washington, D.C.). Additional information included: (1) suggested amendments to the Medicare-Medicaid Programs to extend migrant workers coverage, (2) summary of nutritional problems in the Lower Rio Grande Valley, and (3) bilingual staff by project and region. (NQ)

****
* Documents acquired by ERIC include many informal unpublished *
* materials not available from other sources. ERIC makes every effort *
* to obtain the best copy available. Nevertheless, items of marginal *
* reproducibility are often encountered and this affects the quality *
* of the microfiche and hardcopy reproductions ERIC makes available *
* via the ERIC Document Reproduction Service (EDRS). EDRS is not *
* responsible for the quality of the original document. Reproductions *
* supplied by EDRS are the best that can be made from the original. *
****

HEALTH SERVICES FOR DOMESTIC AGRICULTURAL WORKERS, 1972

BEST COPY AVAILABLE

RECEIVED
MAR 1 1973
NMSU
E.R.I.C.

JOINT HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

AND THE

SUBCOMMITTEE ON MIGRATORY LABOR

OF THE

COMMITTEE ON LABOR AND PUBLIC WELFARE

UNITED STATES SENATE

NINETY-SECOND CONGRESS

SECOND SESSION

ON

S. 3762

TO EXTEND THE PROGRAM FOR HEALTH SERVICES FOR DOMESTIC AGRICULTURAL MIGRANT WORKERS

AUGUST 1, 1972

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
NATIONAL INSTITUTE OF EDUCATION

THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL NATIONAL INSTITUTE OF EDUCATION POSITION OR POLICY

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

U.S. GOVERNMENT PRINTING OFFICE
84-852 O WASHINGTON : 1972

COMMITTEE ON LABOR AND PUBLIC WELFARE

HARRISON A. WILLIAMS, JR., New Jersey, *Chairman*

JENNINGS RANDOLPH, West Virginia	JACOB K. JAVITS, New York
CLAIBORNE PELL, Rhode Island	PETER H. DOMINICK, Colorado
EDWARD M. KENNEDY, Massachusetts	RICHARD S. SCHWEIKER, Pennsylvania
GAYLORD NELSON, Wisconsin	BOB PACKWOOD, Oregon
WALTER F. MONDALE, Minnesota	ROBERT TAFT, JR., Ohio
THOMAS F. EAGLETON, Missouri	J. GLENN BEALL, JR., Maryland
ALAN CRANSTON, California	ROBERT T. STAFFORD, Vermont
HAROLD E. HUGHES, Iowa	
ADLAI E. STEVENSON III, Illinois	

STEWART E. MCCLURE, *Staff Director*
ROBERT E. NAGLE, *General Counsel*
ROY H. MILLENSON, *Minority Staff Director*
EUGENE MITTELMAN, *Minority Counsel*

SUBCOMMITTEE ON HEALTH

EDWARD M. KENNEDY, Massachusetts, *Chairman*

HARRISON A. WILLIAMS, JR., New Jersey	RICHARD S. SCHWEIKER, Pennsylvania
GAYLORD NELSON, Wisconsin	JACOB K. JAVITS, New York
THOMAS F. EAGLETON, Missouri	PETER H. DOMINICK, Colorado
ALAN CRANSTON, California	BOB PACKWOOD, Oregon
HAROLD E. HUGHES, Iowa	J. GLENN BEALL, JR., Maryland
CLAIBORNE PELL, Rhode Island	ROBERT TAFT, JR., Ohio
WALTER F. MONDALE, Minnesota	

LEROY G. GOLDMAN, *Professional Staff Member*
JAY B. CUTLER, *Minority Counsel*

SUBCOMMITTEE ON MIGRATORY LABOR

ADLAI E. STEVENSON III, Illinois, *Chairman*

HARRISON A. WILLIAMS, JR., New Jersey	ROBERT TAFT, JR., Ohio
WALTER F. MONDALE, Minnesota	J. GLENN BEALL, JR., Maryland
EDWARD M. KENNEDY, Massachusetts	JACOB K. JAVITS, New York
HAROLD E. HUGHES, Iowa	

BOREN CHERTKOV, *Counsel*
EUGENE MITTELMAN, *Minority Counsel*

CONTENTS

APPENDIXES

HEALTH SERVICES FOR DOMESTIC AGRICULTURAL WORKERS, 1972

TUESDAY, AUGUST 1, 1972

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

The joint subcommittees met at 9:35 a.m., in room 4200, New Senate Office Building, Senator Edward M. Kennedy presiding.

Present: Senators Kennedy (chairman of the Health Subcommittee), Stevenson (chairman of the Migratory Labor Subcommittee), and Schweiker.

Committee staff present: LeRoy G. Goldman, Jay B. Cutler, and Boren Chertkov, professional staff members.

Senator KENNEDY. The subcommittee will come to order. The joint hearings of the Senate Health Subcommittee and the Senate Migratory Labor Subcommittee this morning will focus on legislation to extend the Migrant Health Act.

The measure now before the subcommittee, S. 3762, which I introduced with Senator Stevenson and seven other Senators, represents a 5-year extension of this program, with $100 million authorized for fiscal year 1973 and a $25 million increase for each of the following years.

This bill represents a first attempt to bring the level of funding for migrant health care services into some appropriate relationship to the documented level of need.

(The text of S. 3762 follows:)

(1)

92D CONGRESS
2D SESSION

S. 3762

IN THE SENATE OF THE UNITED STATES

JUNE 28, 1972

Mr. KENNEDY (for himself, Mr. CRANSTON, Mr. HUGHES, Mr. JAVITS, Mr. MONDALE, Mr. PELL, Mr. STEVENSON, and Mr. WILLIAMS) introduced the following bill; which was read twice and referred to the Committee on Labor and Public Welfare

A BILL

To extend the program for health services for domestic agricultural migrant workers.

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 "$30,000,000 for the fiscal year ending June 30, 1973," and inserting in lieu thereof "not to exceed $100,000,000 for the fiscal year ending June 30, 1973, $125,000,000 for the fiscal year ending June 30, 1974, $150,000,000 for the fiscal year ending June 30, 1975, $175,000,000 for the fiscal year ending June 30, 1976, and $200,000,000 for the fiscal year ending June 30, 1977".

II

Senator KENNEDY. For the 1 million migrants and the 3 to 4 million seasonal farmworkers who are to be served by the Migrant Health Act, the amount of funding available last year for their health care needs was $5.10 per person. The hopeless inadequacy of this level of commitment is understood by comparing it to the spending of one of the most efficient health delivery services in the Nation, the Group Health Cooperative of Puget Sound, which averaged $138 per person for health costs.

HEW officials privately have estimated that barely 20 percent of the Nation's migrants have been served by the migrant health program. And when the full target population of migrants plus eligible seasonal farmworkers is considered, the percentage served drops to 7 percent.

Currently, the migrant health program supports 102 local migrant health projects which offer some services in approximately 130 counties.

Thus, of the 900 counties in 46 States with migrant or seasonal farmworkers, some 770 are not covered.

The results of this past record of neglect are evident. The average life expectancy of the migrant is under 60; for the average U.S. citizen, it is over 70; and the mortality rate of the migrant due to tuberculosis and other infectious diseases is more than twice the national average.

Perhaps no single group in our Nation continues to be as exploited and unserved as the agricultural migrant worker who harvests the food we consume daily.

A dozen years have passed since the television exposé "Harvest of Shame" told the Nation, as did Steinbeck a generation earlier, of the brutal conditions endured by the Nation's farmworkers.

Yet, we still find migrant workers with incomes that average approximately $2,100. We still find migrant workers in substandard housing. We still find migrant workers denied the protection of the law.

These men and women continue to travel the stream working for subsistence wages because their own dignity and self-esteem forces them to seek work wherever it can be found rather than to resign themselves to public indigency. In reality, they are subsidizing the meals we eat, for their exploitation means lower costs to growers, savings which may or may not be translated into lower prices at the supermarket for the fruits and vegetables we buy.

The Migrant Health Act is a recognition that the Nation's farmworkers represent a considerable interstate resource. Without them, there would be no peaches from Washington, no lettuce from California, no tomatoes from Ohio, no asparagus from Colorado, no citrus from Florida, and no cherries from Michigan.

Today, we shall hear first from the administration which has recently issued final regulations designed to carry out the mandate of the 1970 migrant health amendments for greater consumer participation in the migrant health projects. We also shall hear from those on the local level who are working with migrant health projects and from those who are directing those projects. In addition, we shall receive testimony from the chairman of the Migrant Health Advisory Committee and from attorneys who have closely followed the administration of the migrant health program.

During these hearings today, we will examine the need and desirability of expanding the measure now before the subcommittee to provide adequate funding to cover the costs of hospitalization. We also hope to evaluate the experience with the various project models to insure that additional funds will have the greatest impact in delivering comprehensive health care services to the Nation's seasonal farmworkers and migrant workers.

We can no longer ask the farmworkers to wait as we talk of future programs or innovative strategies and expect them to believe us. If we are to retain any credibility as legislators and Federal officials, we must begin this year to provide adequate funds to enable migrant health programs to deliver decent health care services. The farmworkers should demand no less and we should provide no less.

Senator Stevenson.

Senator STEVENSON. Thank you, Senator Kennedy. I can add little to that fine statement.

Today, as in the past, migrant and seasonal farmworkers and their families are poor, rootless, effectively disenfranchised, and ineligible to participate in community health resources, even when available. They are the most likely to be bypassed by national health gains. A categorical health program directed to their specific needs would seem essential to their unique needs.

The migrants' access to health care programs, including medicaid, medicare, food stamps and commodities, and private sector health services, is difficult at best. Constant mobility makes continuity of services difficult; the temporary nature of their work makes migrants transients for whom communities often feel little responsibility; and, rural areas frequently lack sufficient health facilities to meet the needs of local residents, let alone the needs of people who are not residents.

Farmworkers are victimized by an incidence of disease, infant mortality, malnutrition, and other health deficiencies unsurpassed by any other sector of the population. Tuberculosis is 17 times more frequent, and infestation with worms 35 times more frequent, among migrants than among the usual patient. Infant mortality and death from tuberculosis and infectious diseases is 2½ times the national average. Mortality from accidents is nearly three times the national average. Epidemics of polio have recently occurred in areas of high concentration of migrants; nutritional disease is common; extreme obesity due to carbohydrate diet is common; significant protein malnutrition persists; and ostitis in children and degenerative disease in older individuals is common. Dental problems abound; speech, hearing, and vision defects are common; as are mental and emotional disorders; intestinal parasitism, diabetes, thyroid, and degenerative heart diseases.

The Migrant Health Act, first passed in 1962, permits grants to pay part of the costs of family health service clinics and special projects to improve health services. The initial funding level of $750,000 has now been increased to an authorized $30 million for fiscal year 1973. With these funds an effort is made to serve over 1 million migrants and their dependents and over 5 million seasonal workers and their dependents.

One hundred and seventeen single and multicounty health projects assist farmworkers in 317 counties in 36 States. One hundred and seventy hospitals and 1,000 physicians are involved. Yet it is estimated

that these programs meet less than 5 percent of the need. Additionally, five community health projects provide comprehensive ambulatory health care to migrant and seasonal farmworkers in medically underserved rural areas. These consumer-controlled projects appear to be among the best examples of effective programs to meet farmworker needs.

Despite these gains, family clinics are overcrowded with patients during the harvest season; 600 counties continue to lack a system of health care for migrant workers. The fiscal year 1971 appropriation of just under $25 million provides about $2.50 of care per migrant, and $5 per seasonal farmworker.

S. 3762 would extend the migrant health program for 5 years. It provides $100 million for fiscal year 1974, raised to $250 million in 1978.

I hope that during the hearings consideration will also be given to farmworker participation in the development and implementation of national health programs and the coordination of Government health programs so as to eliminate duplication of services.

Senator KENNEDY. We are happy to welcome this morning representatives of the Administration, Dr. Merlin K. DuVal, Assistant Secretary for Health and Scientific Affairs; accompanied by Dr. Vernon Wilson, Administrator, HSMHA; and Dr. Paul Batalden, Director, Community Health Services; Billy Sandlin, Chief, Migrant Branch; Dr. John Zapp, Deputy Assistant Secretary for Legislation.

We understand that Dr. DuVal has to meet with the Soviet Minister of Health at 10, so we appreciate very much your being kind enough to join with us early this morning, and we will understand completely when you have to leave. Feel completely free to do so.

STATEMENT OF DR. MERLIN K. DUVAL, ASSISTANT SECRETARY FOR HEALTH AND SCIENTIFIC AFFAIRS, ACCOMPANIED BY DR. VERNON WILSON, ADMINISTRATOR, HSMHA; DR. PAUL BATALDEN, DIRECTOR, COMMUNITY HEALTH SERVICE; BILLY SANDLIN, CHIEF, MIGRANT BRANCH; DR. JOHN ZAPP, DEPUTY ASSISTANT SECRETARY FOR LEGISLATION

Dr. DUVAL. Thank you, Mr. Chairman. I am pleased to appear today before both the Subcommittee on Health and the Subcommittee on Migratory Labor to discuss with you the migratory health program and legislation which would extend the authorization for project grants to improve health services for migrant agricultural workers and their families. The bill under consideration, S. 3762, introduced by you and other committee members, Mr. Chairman, would extend authorization for the program for an additional 4 years, fiscal year 1974 through fiscal year 1977, and would authorize appropriation levels for fiscal years 1974 through 1977 of $125 million; $150 million; $175 million; and $200 million, respectively. In addition, the bill would also increase the current authorization level for fiscal year 1973 from $30 million to $100 million.

The Migrant Health Act was initially approved on September 25, 1962, as Public Law 87-692 and became section 310 of the PHS Act. Basically, it authorizes the Secretary to make grants to public and

other nonprofit agencies, institutions, and organizations for paying part of the cost of:

1. Establishing and operating family health service clinics for domestic agricultural migratory workers and their families, including training persons to provide services in the establishing and operating of such clinics, and

2. Special projects to improve and provide a continuity in health services for and to improve the health conditions of domestic agricultural migratory workers and their families, including necessary hospital care, and including the training of persons to provide health services for or otherwise improve the health conditions of such migratory workers and their families.

As revised in 1970, the act further permits the Secretary to use funds appropriated to provide health services to persons (and their families) who perform seasonal agricultural services similar to the services performed by domestic agricultural migratory workers if the Secretary finds that the provision of health services under this authorization will contribute to the improvement of the health conditions of such migratory workers and their families.

Migrant farmworkers and families present a unique problem in the planning and delivery of health care. They are unequally distributed over the Nation's States and counties. They reside in particular places for only brief periods of each year. In each place they are strangers. Many—although they have been American citizens for a generation or two—still speak Spanish more easily than English. Some speak no English at all. Wide dispersion in isolated areas, lack of familiarity with their temporary communities, fear of community hostility, unfamiliarity with modern health concepts and practices, voicelessness in community planning—all contribute to making migrants forgotten citizens when it comes to local provision of health and other services. Even when States and localities recognize their needs and try to plan for them, great difficulties are encountered.

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

We believe the migrant health program has made progress in overcoming these problems. The measurement of progress is complex because the basic demographic data that we regularly use and depend upon to assess the impact of most of our health programs is not available for migrants.

Senator KENNEDY. What do you consider the percent of migrants that are covered now by your health program?

Dr. DUVAL. Currently, I would estimate we are reaching maybe 9 to 10 percent. It would depend a little upon what you mean by covered, because clearly we may be making contact with more than that, but we may not be meeting all their needs, especially in hospitalization.

To help us more effectively plan and evaluate our program efforts, we have attempted to assess the magnitude of migrant workers' influx to a given county. By identifying high and low migrant impact counties, it is possible to identify priority program strategies for these communities.

Approximately one-third of all migrant workers are estimated to reside in 20 high-impact counties. We have funded the delivery of health services to approximately one-third of the target population in these high-impact counties. The remaining two-thirds of the migrant population is found in medium- or low-impact (less than 10,000 migrant farmworkers at peak season) counties. The migrant health program served approximately one-fifth of that population. We should note that this type of dispersion seriously inhibits the delivery of health services generally, both to migrants and other rural inhabitants.

With the fiscal year 1972 appropriation of $17,950,000, the migrant health program provided services to 259,000 farmworkers during fiscal year 1972. These health services were delivered through 460,000 visits in 101 projects. Assuming a total target population for our projects of 1.2 million, this represents 21 percent coverage of our target population. For fiscal year 1973, we are requesting $23,750,000 and anticipate serving 284,000 farmworkers.

Improvements have also been made in the assurance of greater social accountability of the health care provided in our projects. In May of 1972, migrant health regulations were issued.

The standardization of benefits available to migrants from migrant health projects is another clear outcome of the newly published regulations.

The intent of the regulations is to bring the dollars paying for the services closer to the people who receive those services. While it is too early to anticipate complete response in this area, preliminary indications suggest that our intent is being served.

Mr. Chairman, the administration has proposed the family health insurance plan (FHIP) which will greatly improve the financing of health services for all low-income families including migrant families. We believe the foregoing activities of the migrant health program will provide the resource base upon which the financing provided in FHIP can build.

In summary, progress in our migrant health program has been real. More people have been served with higher quality services and with greater consumer participation than ever before.

We are continuing to explore solutions to the major health problems of the migrants. In fact, at the present time, we are conducting an intensive review of the migrant health program. Major unresolved issues currently under review include the role of third-party coverage, the availability and accessibility of health resources, and hospitalization.

As a result of our studies to date, we have formed an initial conclusion that the potential reimbursement available to migrants under the medicare program is negligible. Few migrants are eligible for benefits under this program. The migrant population is essentially a young working one, and thus few migrants live to be covered under medicare. Those that do are seldom still in the migrant labor pool.

Senator KENNEDY. Part of the medicare qualifications is done on wages rather than piecework, and most of the migrants are doing piecework and therefore fail to fall under eligibility?

Dr. DUVAL. The problem with medicare would be, first, that the age groupings are different and, secondly, there would be certain copaying aspects of medicare.

Senator KENNEDY. I am wondering whether the Congress should not try, as a matter of equity, to provide the same kind of consideration for piecework as it does for wages. Obviously, as you point out, there is a difference in age. In those areas where they would qualify otherwise because of age, they are basically discriminated against because of different qualification of payment. I do not know whether this should be an area of interest. I raise it now and wish you would give some thought to it and see if we cannot work something out on it.

Dr. DUVAL. The problem with medicaid is a different one. Many migrants are technically eligible for health care coverage through the medicaid program which finances health care coverage for low-income individuals and families. In practice, however, many migrants do not receive medicaid-covered services because they do not meet State residence requirements or because their incomes exceed the State limits for the "categorically needy" employed under medicaid.

Senator KENNEDY. Under the residency requirements, refresh my recollection on this, did the Supreme Court not rule on the questions of residency requirements some time ago? Does that apply?

Dr. DUVAL. Yes. This is correct, Senator. As I understand it, these are being translated one by one by the States into an appropriate resolution of the problem. I believe that is an in-between process at the moment.

Dr. BATALDEN. The intent to reside is now replacing actual residency requirements, and that tends to effectively eliminate migrants.

Senator KENNEDY. Why do they not intend to reside if they are working there? What is it within your regulations, in your interpretations, that suggests their intention is not to reside?

Dr. DUVAL. I think it is even more complicated than that. It is not just limitation on residency. There are certain prerequisites obviously, categorical in nature, for eligibility of medicaid, and take certain amount of processing to be eligible. Under the circumstances a person moving rapidly from community to community, such as migrant worker, may actually not be able to achieve eligibility under medicaid in States irrespective of residency.

Senator KENNEDY. I agree with that. What percent of the migrants fall within or are eligible under medicaid? Do you have any figures on that? It is somewhere around 5 percent as I understand it.

Dr. BATALDEN. We think it is no more than 10 percent at the maximum.

Senator KENNEDY. I heard it was approximately 5. If income were the sole requirement, what percent would be eligible for the medicaid?

Dr. BATALDEN. Assuming all the States had the medically needy clause, what percent would qualify?

Senator KENNEDY. These are all on the other kinds of exclusions, whether the father remains in the home and other things, which work to the disadvantage in many instances of the migrant, and I think it is very unfortunate. But I was just wondering as far as their income goes, what percent would be eligible?

Dr. BATALDEN: They would all be eligible.

Senator KENNEDY. It is useful for us to remind ourselves about the administrative or legal blocks that exist in those laws which can be altered and should be changed by congressional action. I would like to find out where the blame is due. It is important for us to understand what those blocks are. Too often we think we are getting by them and we find out we are not. Would you continue?

Dr. DUVAL. Yes, sir. At the same time, we are making continuing progress in recovering reimbursement that is available for migrant care through the State medicaid programs. State medicaid agencies have been directed by DHEW to assure that comprehensive migrant health clinics, because of their close administrative and services ties to the OEO and 314(e) comprehensive health centers, be reimbursed with medicaid funds on the same basis as the OEO and 314(e) centers.

Generally, the migrant population is geographically scattered and mobile. Nevertheless, it tends to be concentrated in predominately rural areas which suffer from problems where maldistribution of health resources are scarce. The lack of available resources affects not only the migrants but many of the persons who reside in rural areas. This is a very complex problem for the migrant as well as the rest of the rural population, for which no easy solution has been developed. The answer to this problem must be part of a general approach to cope with the shortage and maldistribution of resources to meet the needs of both the resident rural population and the migrants.

By all available indicators, migrants continue to be victimized by serious health problems much more frequently than the general public. Yet, migrants have considerably fewer hospitalizations than their healthier peers. Though adequate statistics are wanting, there is little doubt that the migrants would benefit from easier access to hospital care.

A number of barriers prevent more effective use of hospitalization. Most prominent among these is the cost of hospital care. Because the hospital component is the most expensive part of any health care program, migrants are generally admitted to hospitals only under emergency conditions. As indicated earlier, financing for migrant hospital care is not readily available. At the present, the limited hospital care that migrants do receive is financed primarily by the migrant health program through its projects under emergency situations and by local public and county hospitals through their charitable activities. As I implied earlier, enactment of the administration proposed family health insurance plan, however, will alleviate the current problem, inadequate financing for migrant's hospitalization.

Migrant health needs are complex and varied. In some respects migrant and seasonal farmworker health problems are a manifestation of the problems that face many rural Americans in obtaining adequate health care. In microcosm, migrants have problems with financing, with availability of resources and accessibility to care. In addition, cultural and language barriers make obtaining adequate services difficult for the migrants. The mobility of a migrant population further complicates the problem and makes the provision of comprehensive health care with continuity a very difficult one indeed. A solution to the delivery of health care services to the rural population in general will represent a major step in the solution to the problems of delivering health care to the migrant populations.

As I indicated earlier, we are reviewing the migrant health authority in light of the aforementioned problems to determine what, if any, changes need to be made. Sufficient authority currently exists for the conduct of migrant health activities in fiscal year 1973, so that there is no compelling need to extend to those authorities at this time.

Generally, Mr. Chairman, we are currently reviewing all PHS authorities that expire at the end of fiscal year 1973, with a view to identifying necessary and desirable amendments. We anticipate submitting our detailed legislative recommendations in connection with the fiscal year 1974 budget. We, therefore, request your cooperation in not extending the migrant health authorities until we have completed our review. Accordingly, we recommend against enactment of S. 3762, at this time.

Senator KENNEDY. We have heard different words with the same tune before. You are fully aware of our reasons for trying to move ahead in this area and in the other areas as well that have been identified. I have a couple of quick questions for you and then we will move along.

In your testimony you indicate the studies are underway, reviews are being considered. You have talked at the top of page 6 about exploring solutions to major health programs of migrants, conducting an intensive review of the migrant health program, and you ask us to delay because you are continuing to review these recommendations and the development of your legislative budget. It has been drawn to my attention that you have got an awful lot of studies that have been completed by HEW, such as the migrant task force study, the California regional office study, and so on; six different studies and reviews have been done and completed. What has happened to all these reports?

Dr. DUVAL. As you have already indicated, many of these are already in. The answer is that we are attempting to seek, to put into perspective our plans for the 1974 budget, which are not solely contingent upon the outcome of those studies. Rather the issue was how best to fit the total requirements of a proper migrant health package into the other related and in many instances overlapping pieces of legislation that will expire in 1973, and get them appropriately innovated.

We have had increased communications with the State health officers and the ultimate use of the 314(d) moneys may relate very heavily to the matter in which the migrant health program is structured. Similarly with 314(e) project grants. It is to properly integrate these programs that we wanted the additional review.

Senator KENNEDY. You have your community change study; the report on 12 months study of migrant health programs, including visits to 23 federally funded migrant health projects in 10 States—10 State and regional offices; and so on. You have evaluations of ongoing migrant health programs, evaluation of State and regional headquarters administration, evaluation of projects, projection of migrant health needs, analysis of alternatives, models to improving health care delivery.

How much more do we need for study?

Dr. DUVAL. I would suggest the answer I gave while it may not seem adequate, it does tend to put it into perspective. The issue is not

the results of those studies, but rather how the results of those studies, those that are incomplete as well as complete, fit into a larger strategy in terms of integration of migrant health program with others that we are also obliged to operate.

Senator KENNEDY. We are still caring for just about 10 percent of the migrant workers. When migrant workers hear we are going to do some more studies about how we are going to work migrant health programs into more comprehensive health delivery legislation, I can understand why many of the migrants themselves feel that they are just going to be perennially studied.

Dr. DUVAL. If the interpretation is that we are waiting for the results of the study, I would concur that this would be unfortunate. The issue of the study as I tried to state is not why we are delaying. We are delaying in order to fit this into a larger strategy, in view of the fact that much money that is appropriated and expended through the Department is on many programs that can be of singular benefit to the migrant through other routes than migrant health programs. It is essential that that be tapped and fitted into migrant health programs. We do not need additional studies——

Senator KENNEDY. Those are already in existence; are they not?

Dr. DUVAL. They are, but some of them are quite new, and we have not yet matured in our experience.

Senator KENNDY. Can you tell us a little about those consumer developed migrant health programs in California? As I understand from studies that have been made within HEW, they have been enormously successful; yet, there is a freeze put on those funds. And as I understand further, unlike freezes that have been taking place in other consumer programs, I also hear that that is primarily because of the local medical societies' objections to these programs. I am wondering what you can tell us about it?

Dr. DUVAL. I have no information that there is objection from the medical societies. The problem that has emerged in California, Mr. Chairman, relates to the fact—as a matter of fact in its own way it is a criterion of success—in California there are enormous numbers of energies working to solve problems of which this is only one expression; and there are a lot of innovation and interesting new programs going on in California.

What has happened in California, as a consequence of this, is that these programs are rising in California as well as other Federal investments, and we have now reached a point of enormous duplication and overlap.

All that has happened is, the Director of HSMHA has requested that a site team examine the current situation in California and make recommendations as to the best way in which we can improve on the current situation there. That team has examined the local circumstances and has suggested that a master plan be created for subsequent development in California.

The basic pieces of the master plan are pretty well known. So when we receive that information, we stop further development of California projects awaiting the structure of the master plan, which we expect this month, after which we will then have the new projects fit a somewhat larger strategy.

Dr. BATALDEN. There was no selective attempt to specifically freeze one type of project. All projects in the State of California were frozen.

Senator KENNEDY. Everything in California has been frozen.

Mr. DUNCAN. "Freeze" may be a difficult word. I would not equate this type of holding up of the expansion of programs, to the freeze that was placed on legal aid services.

Senator KENNEDY. How would you distinguish it? I suppose in one they were not going to get any money at all. The other one they just held at their level.

Mr. DUNCAN. It is expansion activities that are being held up until we can determine how those best fit into the overall plan.

Senator KENNEDY. That study was completed in February, as I understand it?

Mr. DUNCAN. Correct.

Senator KENNEDY. When do you think that is going to be freed? What can you tell us about the lifting of the freeze or ceiling or whatever?

Mr. DUNCAN. Dr. DuVal has indicated this month, and I certainly think we can meet that timetable in terms of resolving the issues.

Senator KENNEDY. Is there anything you can tell us about the various programs? Are you going to permit expansion of consumer-dominated programs, or is there going to be a change in emphasis?

Mr. DUNCAN. I certainly see no change in the continuing focus and improvement of consumer participation in the projects, whatever the strategy that is developed.

Senator KENNEDY. As I understand—and correct me if I am wrong—the HEW study recommended highly the consumer-related base programs and recommended the funding of some of the county health department programs; is that correct?

Mr. DUNCAN. That is essentially correct.

Senator KENNEDY. Can you tell us whether your recommendations are going to follow that report?

Mr. DUNCAN. That is what we are still working on.

Senator KENNEDY. Is the report available? Is there any reason we could not see that report?

Mr. DUNCAN. The report has not been publicly released. We are holding it until we have responses from both our regional office staff and program community health service staff.

Senator KENNEDY. When will you have those?

Mr. DUNCAN. That is part of the resolution to be accomplished this month.

Senator KENNEDY. After you get those responses, is there any reason we cannot have that report?

Mr. DUNCAN. I would see no reason why not.

Senator KENNEDY. I would like to ask a little bit about that hospitalization, and maybe we could submit some written questions; because I know you have to leave.

I saw the Hospital Association yesterday talk about $92 per day in a hospital now. I know we are going to hear later in the morning about some incidents in which migrants did not have some of the money to put down and were therefore denied entrance, with absolutely tragic results. Could you tell us what you think can be done by the administration?

Dr. DuVal. Clearly, this is the most difficult area. As you know, in the last go-round with the legislation, the authority to use appropriations to cover hospitalization was added to the original Migrant Health Act, and we are cognizant and alert to this possibility that the legislation permits.

This past year, what we have done is managed to reach a level of 96 of the 101 projects that now have made the necessary arrangements locally in their communities so that hospitalization can be arranged. We have not been successful, of course, in reaching the point at which the program itself could be the source of funding for hospitalization. The expense is so very great that if we were to categorize or predetermine that the migrant health program funds be expanded on hospitalization, it would wipe out the gains on the other sides of the program. We have currently put in approximately $300,000 to $400,000 from migratory health programs, and another $600 to $1,200 from State and local sources, and covered about a million dollars of hospital bills this year.

We acknowledge that this is a small part of getting started on the hospitalization question, and it is clear a somewhat broader strategy is going to be necessary.

Senator Kennedy. This is an area of very significant need. I think all of us realize the importance of trying to encourage ambulatory care and out-of-hospital service of treatment and all the rest; but unquestionably there are some very serious situations where again the migrants have been unable to take advantage of hospitalization.

Are you prepared to offer or recommend some increase in funding next year on those sections? What can you tell us about that?

Dr. DuVal. There is no way I can tell this far in advance whether we would recommend increased funding for that. I think our concern would be cost of hospitalization for migrants, as well as others, who need care and who are not privileged to be in hospitals. We would want to fit the total strategy in which migrants are coequally treated as anyone else.

Senator Kennedy. Under your regulations, have you got a figure of what it would cost for hospital care for migrants?

Dr. DuVal. That would be sort of a new math, Senator; and it would be a little hard. I would estimate the total cost of meeting all requirements of migrant workers might run to $600 million.

Senator Kennedy. That is with hospitalization?

Dr. DuVal. Yes, sir.

Senator Kennedy. That is just hospitalization, or is that total?

Dr. DuVal. That would be total for migrants, plus seasonal workers, since seasonal farmers are embraced by the same legislation.

Senator Kennedy. Give us the range of services under the regulations, the various elements that are to be provided. Delivery of family health care should include ambulatory health care, followup to insure continuity, hospitalization, transportation, et cetera.

How much of that set of benefit requirements do you think are really reaching migrant seasonal workers? They are just new regulations and they are good regulations in this respect—this is what we are trying to do in all the areas, to try to show what people are entitled to.

You can talk about improving health care; I think it is much better to get good regulations written down. I have suggestions in terms of the range of services, and I am sure we could debate those.

I suppose the next question is what you anticipate: What percent of migrant workers or seasonal workers will actually receive those range of services over the period of next year?

Dr. DuVal. The question actually does not have an answer, but only for a reason that I believe I could explain.

While 50 percent of the projects embrace the great majority of the services listed on that list, there is no way of computing on that what proportion the migrants themselves might have access to particular services. The reason again is inherent in the fact that they are migrators. They can migrate into one area where they have that service available and go to another area where they do not. There is no way you can compute what proportion of migrants have access to that particular panoply.

Senator Kennedy. You would be able to keep a list of services available and know the number of migrants in a given area of the country; certainly you would be able to figure it out pretty well, so that there are a certain number of children under these programs that have had their teeth fixed and so on; and you can make some evaluation as to what the needs are.

Is it somewhere between 5 and 10 percent, would you think?

Dr. DuVal. I would think that would be a reasonable guess. It will take time under these regulations. It is necessary for us to get the figures back from the field.

Senator Kennedy. It is your view that hospitalization care be required, aspects of the federally funded project?

Dr. DuVal. It would be my view at this time that the opportunity to have the project include the cost of hospitalization is desirable. I would not wish to mandate that we must meet cost of hospitalization, for example, prior to some other cost; because at any given time total resources may not be adequate to do an entire job, and there may be a reason to put one ahead of another in a sense of priority.

Senator Kennedy. I have a series of questions. I know you have to go; and we will submit them to you and would like to get your written response.

Dr. DuVal. My colleagues would be happy to remain should you prefer to do it that way; but you know we will respond in writing.

Senator Kennedy. Maybe if your colleagues could stay for a while longer, and then I will have a series of questions in writing.

What is being done to increase the number of Spanish-speaking personnel in these various clinics? What can you tell us about that?

Dr. Batalden. Our projects currently employ about 580 bilingual individuals. There are bilingual staff in 70 percent of the projects.

Senator Kennedy. Bilingual staff in 70 percent of the projects.

In terms of the total number of personnel that work on projects, and the number of, say, Spanish surnames.

Dr. Batalden. There are 580 bilingual people in the projects. The total number of full-time equivalents in the projects is 829.

Senator Kennedy. Permanent personnel in these projects?

Dr. Batalden. These are full-time equivalents. I cannot give you the breakdown whether this is permanent person or whether that person works there half a day——

Senator Kennedy. Could you provide the job level?

Dr. Batalden. We can provide that for you.

Senator KENNEDY. How many administrators of these projects are Spanish?

Dr. BATALDEN. We can provide that.

Senator KENNEDY. Would you provide that for us?

Dr. BATALDEN. Surely.

Senator KENNEDY. Those involved, say, in the program, even here in Washington.

Dr. BATALDEN. Surely.

Senator KENNEDY. And in the regional office.

Dr. BATALDEN. We will provide that.

Senator KENNEDY. I have other questions, but I want to hear from some of our groups that have come from different parts of the country, and we will get the questions to you.

Thank you very much, gentlemen.

Dr. BATALDEN. Thank you.

(The information referred to and subsequently supplied follows:)

REGION I

Regional Office Migrant Program Employees with Spanish-Surnames 0

Number of Directors/Administrators of Migrant Projects Who Are Spanish-Surnamed 2

Bilingual Staff by Project:

PROJECT	STAFF		SALARY
New England Farmworkers Council Springfield, Massachusetts	1	Program Director	$17,000
	1	Administrative Assistant	10,400
	1	Secretary	5,720
	2	Assistant Coordinators	@ 8,000
	8	Health Aides	@ 6,500
	4	Teachers	@ 6,500
	17	TOTAL	
Shade Tobacco Growers Association Windsor, Connecticut	1	Program Coordinator	$11,000
	2	Health Aides	@ 6,500
	1	Driver	6,000
	1	Director	N/A
	5	TOTAL	

REGION II

Regional Office Migrant Program Employees with Spanish-Surnames 1

Number of Directors/Administrators of Migrant Projects Who Are Spanish-Surnamed 2

Bilingual Staff by Project:

PROJECT	STAFF		SALARY
Rochester General Hospital Rochester, New York	2	Community Health Workers	@$ 5,400
	2	TOTAL	
Warwick Area Migrant Committee, Inc. Warwick, New York	2	Nursing Aides	@$ 9,000
	1	Physician	50 per 3 hrs.
	1	Secretary/Interpreter	6,000
	1	Medical Records Aide	9,000
	5	TOTAL	
Project REACH, Inc. Perkinsville, New York	1	Field Worker	$ 5,400
	1	TOTAL	
University of Rochester School of Medicine Rochester, New York	2	Health Education Aides	@$ 5,615
	1	Interviewer	5,500
	1	Community Health Nurse	9,000
	4	TOTAL	
Suffolk County Health Department New York, New York	2	Community Aides	@$ 5,000
	1	Physician	28,000
	3	TOTAL	
University of Puerto Rico School of Medicine San Juan, Puerto Rico	1	Project Director	$26,880
	1	Administrator	7,200
	2	TOTAL	
State Health Department Mayaguez, Puerto Rico	1	Project Director	$20,000
	1	Assistant Administrator	5,400
	1	Health Educator	7,200
	3	TOTAL	

Page 3

PROJECT	STAFF		SALARY
New Jersey State Department of Health Trenton, New Jersey	1	Outreach Worker	$ 5,980
	1	Clerk/Interpreter	4,420
	2	TOTAL	
Board of Chosen Freeholders of Salem County Salem, New Jersey	1	Nurse	$ 8,400
	1	Social Service Worker	7,400
	1	Clerk	4,200
	2	Outreach Workers	@ 4,000
	2	Nursing Aides	@ 6,000
	7	TOTAL	
Board of Chosen Freeholders of Cumberland County Bridgeton, New Jersey	1	Aide	$ 6,500
	1	Medical Director	40,000
	2	TOTAL	

REGION III

Regional Office Migrant Program Employees with Spanish-Surnames 0

Number of Directors/Administrators of Migrant Projects Who Are Spanish-Surnamed 1

Bilingual Staff by Project:

PROJECT	STAFF		SALARY
Conference of Major Superiors of Women Washington, D.C.	1	Assistant Administrator	$ 7,200
	1	Health Aide	4,600
	1	RN	7,500
	1	Health Educator	7,800
	1	Secretary	8,040
	1	Aide - Driver	6,900
	6	TOTAL	
Pennsylvania Department of Health Harrisburg, Pennsylvania	1	Field Coordinator	$10,000
	1	Technical Aide	5,400
	1	Physician	N/A
	3	TOTAL	
Geisinger Medical Center Danville, Pennsylvania	1	Research Director	$18,000
	1	TOTAL	

REGION IV

Regional Office Migrant Program Employees with Spanish-Surnames 0

Number of Directors/Administrators of Migrant Projects Who Are Spanish-Surnamed 1

Bilingual Staff by Project:

PROJECT	STAFF		SALARY
Palm Beach County Health Department West Palm Beach, Florida	1	Comprehensive Health Worker	$ 4,430
	1	Vehicle Operator	4,794
	1	Home Health Aide	4,663
	1	Dentist	23,000
	1	Nurse	15,000
	5	TOTAL	
Community Health of South Dade, Inc. Miami, Florida	6	Medical Doctors	@$24,000
	1	Coordinator	18,000
	1	Nurse	10,400
	1	Drug Room Supervisor	5,200
	4	Clinic Aides	@ 4,836
	1	Record	5,400
	2	Record Clerks	@ 4,836
	3	Social Service Aides	@ 4,836
	1	Community Development & Transportation Supervisor	10,000
	1	Maid	3,495
	1	Maintence Man	5,200
	2	Drivers	@ 5,400
	24	TOTAL	
Lee County Health Department Ft. Myers, Florida	3	Community Health Workers	@$ 4,243
	3	TOTAL	

Page 6

PROJECT	STAFF		SALARY
Sarasota County Health Department Sarasota, Florida.	1	Community Health Worker	$ 4,243
	1	TOTAL	
Florida Department of Health and Rehabilitative Services Jacksonville, Florida	1	Physician	$22,000
	1	TOTAL	
Collier County Health Department Naples, Florida	1	Vehicle Operator	$ 4,669
	1	Clinic Aide	4,243
	2	Community Health Workers	4,243
	4	TOTAL	
Hendry County Health Department LaBelle, Florida	1	Community Health Worker	$ 4,243
	1	Clinic Aide	4,666
	2	TOTAL	
Hillsborough County Health Department Tampa, Florida	1	Clinic Aide	$ 4,461
	1	TOTAL	

REGION V

Regional Office Migrant Program Employees with Spanish-Surnames 3

Number of Directors/Administrators of Migrant Projects Who Are Spanish-Surnamed 4

Bilingual Staff by Project:

PROJECT	STAFF		SALARY
Jones Memorial Community Center Chicago Heights, Illinois	1	Health Aide	$ 5,200
	1	TOTAL	
Illinois Migrant Council Chicago, Illinois	2	Outreach Nurses Aides	@$ 5,000
	2	TOTAL	
AMOS, Inc. Indianapolis, Indiana	3	RNs	@$ 9,360
	2	LPNs	@ 7,280
	5	Clinic Aides	@ 4,160
	1	Physician	41,600
	11	TOTAL	
Benzie Migrant Services Benzie, Michigan	1	LPN	$ 5,928
	1	Physician	52,000
	1	Physician	N/A
	1	Registrar/Clerk	5,200
	4	TOTAL	
East Central Michigan Health Service, Inc. Saginaw, Michigan	1	Assistant Project Director	$15,000
	1	Secretary	6,139
	3	Pharmacists	@ 14,248*
	1	Health Aide	6,032*
	15	Health Aides	@ 5,824
	6	Clinic Clerks	@ 5,824*
	2	Clinic RNs	@ 10,400*
	1	Acting Project Director	14,000
	1	Health Aide	4,470
	1	RN	8,965
	31	TOTAL	

PROJECT	STAFF		SALARY
Ohio Department of Health Columbus, Ohio	1	Health Aide	$ 3,600
	1	Health Aide	3,636
	1	Health Aide	3,900
	5	Health Aides	@ 4,200
	1	Health Aide	4,380
	2	Health Aides	@ 4,500
	1	Health Aide	4,560
	2	Health Aides	@ 4,944
	2	Health Aides	@ 4,980
	2	Health Aides	@ 5,304
	1	Health Aide	4,160
	1	Secretary	4,800
	1	Secretary	4,920
	1	Secretary	5,160
	1	Secretary	5,700
	1	RN	8,580
	2	Registrars	@ 4,164
	1	Registrar	4,680
	1	Registrar	4,920
	1	Registrar	4,500
	12	Physicians	@ 52,000
	2	Custodians	@ 4,368
	1	Administrator	9,360
	44	TOTAL	
Catholic Diocese of Green Bay Wautoma, Wisconsin	1	Director	$ 9,700
	6	Health Aides	@ 5,200
	1	Nutritionist	10,300
	8	TOTAL	

PROJECT	STAFF		SALARY
Berrien County Health Department St. Joseph, Michigan	1	Hospital Representative	$ 6,700
	1	Hospital Representative	6,760
	1	Migrant Coordinator	9,000
	1	Clerk	4,875
	1	Health Education Assistant	5,512
	1	Health Education Assistant	4,680
	1	Lab Technician	9,540
	1	Health Aide	5,400
	8	Health Aides	@ 4,680
	1	Health Aide	4,472
	2	RNs	@ 8,320
	2	Health Aides	@ 5,970
	2	Clerks	@ 4,680
	1	Receptionist	4,680
	1	Aide	5,970
	1	Nurse Aide	5,970
	1	Physician	52,000
	1	Dental Hygienist Student	5,600
	1	Hospital RN	8,400
	3	Clerical Health Aides	@ 4,500
	1	Outreach Aide	4,500
	5	Health Aides	@ 4,500
	38	TOTAL	
Western Michigan Comprehensive Health Services Baldwin, Michigan	2	Interpreters	@$ 4,160
	2	TOTAL	
Minnesota Department of Health Minneapolis, Minnesota	6	Staff Nurses	@$ 8,300
	7	Health Assistants	@ 4,600
	1	Coordinator	14,148
	1	Senior Nurse	10,332
	1	Clerk	4,896
	1	Clerk	5,304
	17	TOTAL	

REGION VI

Regional Office Migrant Program Employees with Spanish-Surnames 1

Number of Directors/Administrators of Migrant Projects Who Are Spanish-Surnamed 14

Bilingual Staff by Project:

PROJECT	STAFF		SALARY
Las Cruces Committee on Migrant Health Las Cruces, New Mexico	1	Project Director	$9,000
	1	RN	7,800
	1	Clerk	4,300
	3	TOTAL	
New Mexico Department of Health and Social Services - District V Las Vegas, New Mexico	1	RN	$7,900
	1	Steno/Clerk	4,000
	2	Aides	@ 4,200
	1	Sanitarian	7,200
	5	TOTAL	
New Mexico Department of Health and Social Services - District I Santa Fe, New Mexico	2	RNs	@$6,200
	1	Social Worker	8,400
	4	Clerk/Stenos	@ 4,800
	6	Aides	@ 5,000
	13	TOTAL	
Cameron County Health Department San Benito, Texas	1	RN	$7,800
	9	LVNs	@ 4,600
	1	Health Educator	11,000
	2	Steno/Clerks	@ 4,900
	5	Aides	@ 3,900
	18	TOTAL	
City Council of Littlefield Littlefield, Texas	1	Aide	$4,300
	1	Sanitarian	7,000
	2	TOTAL	

Page 11

PROJECT	STAFF		SALARY
Hidalgo County Health Care Corporation Edinburg, Texas	1	Project Director	$13,000
	1	MD	30,000
	3	RN	@ 7,800
	4	LVNs	@ 4,700
	4	Steno/Clerks	@ 5,000
	4	Aides	@ 4,000
	2	Sanitarians	@ 7,000
	19	TOTAL	
Plainview-Hale County Health District Plainfield, Texas	2	Aides	@$ 4,200
	2	TOTAL	
San Patricio County Committee on Youth Education and Job Opportunities Mathis, Texas	1	Administrator	$12,000
	1	Physician	20,000
	2	Steno/Clerks	@ 4,500
	1	Aide	4,210
	5	TOTAL	
DeLeon Municipal Hospital DeLeon, Texas	1	RN	$ 7,800
	1	Aide	4,200
	1	Clerk/Typist	4,400
	1	Project Director	7,200*
	4	TOTAL	
San Marcos-Hays County Health Department San Marcos, Texas	1	RN	$ 8,000
	1	Sanitarian	8,300
	2	TOTAL	
Texas State Department of Health Austin, Texas	1	Health Educator	$12,000
	2	Sanitarians	@ 11,000
	1	RN	11,000
	3	Steno/Clerks	@ 5,000
	7	TOTAL	
Zapata County Commissioners' Court Zapata, Texas	1	Project Director	$ **
	1	Medical Director	7,500*
	1	Clerk	4,400
	1	LVH	5,000
	1	Administrator	7,800
	1	Aide	4,400
	6	TOTAL	

Page 12

PROJECT	STAFF		SALARY
Floyd County Commissioners Floydada, Texas	1	PHN	$ 7,300
	1	Aide	4,100
	2	TOTAL	
Jim Hogg County Commissioners' Court Hebronville, Texas	1	RN	$ 6,000
	1	Sanitary Inspector	4,500
	1	Clerk	3,600
	3	TOTAL	
Jim Wells County Commissioners' Court Alice, Texas	1	Project Director	$ **
	1	LVN	4,800
	1	Clerk	4,200
	1	RN	7,800
	4	TOTAL	
La Salle County Commissioners' Court Cotulla, Texas	1	Clerk	$ 5,200
	1	Aide	4,100
	2	TOTAL	
Laredo-Webb County Health Department Laredo, Texas	1	Project Director	$ **
	1	Administrator	14,000
	2	Sanitarians	@ 7,200
	1	Clerk	4,500
	1	Health Educator	10,000
	2	Aides	@ 4,300
	1	LVN	5,200
	2	RNs	@ 7,800
	1	Lab Assistant	6,000
	12	TOTAL	
Zavala County Health Corporation Crystal City, Texas	1	Director	$28,000
	1	Administrator	20,000
	2	TOTAL	
Crosby County Commissioners' Court Cotulla, Texas	1	Nurses' Aide	$ 3,600
	1	TOTAL	
Deaf Smith County Public Health Clinic, Inc. Hereford, Texas	2	Aides	@$ 3,800
	1	LVN	4,600
	3	TOTAL	

Page 13

PROJECT	STAFF		SALARY
Del Rio-Val Verde County Health Department Del Rio, Texas	1	Project Director	$ 6,000
	1	Nurses' Aide	3,700
	1	LVN	5,300
	1	Clerk/Steno	3,600
	1	Dental Hygienist	7,500
	5	TOTAL	
HELP New Mexico	1	Director	$20,000
	1	TOTAL	

REGION VII

Regional Office Migrant Program Employees with Spanish-Surnames 0

Number of Directors/Administrators of Migrant Projects Who Are Spanish-Surnamed 1

Bilingual Staff by Project:

PROJECT	STAFF		SALARY
Muscatine Migrant Committee Muscatine, Iowa	1	Director	$10,500
	1	Nurse	7,000
	1	Nurse	2,200*
	1	Family Planning Aide	4,800**
	2	Health Aides @	1,000
	1	Project Secretary	5,500
	1	Vista Volunteer	2,500**
	8	TOTAL	
Migrant Action Program, Inc. Mason City, Iowa	1	RN	$
	1	Student Nurse	6,000**
	2	TOTAL	
Kansas State Department of Health Topeka, Kansas	1	Nurse	$ 8,500
	1	Health Educator/ Sanitarian	9,780
	1	Health Educator	8,500
	3	TOTAL	
Kansas City-Wyandotte County Health Department Kansas City, Kansas	1	Nurse	$ 7,200
	1	TOTAL	
Nebraska Department of Health Lincoln, Nebraska	1	Sanitation Aide	$ 4,560*
	1	Sanitation Aide	4,800*
	1	Clinic Nurse	7,600
	3	TOTAL	

REGION VIII

Regional Office Migrant Program Employees with Spanish-Surnames 3

Number of Directors/Administrators of Migrant Projects Who Are Spanish-Surnamed 3

Bilingual Staff by Project:

PROJECT	STAFF		SALARY
Utah Migrant Health Project Salt Lake City, Utah	1	Secretary	$ 5,300
	3	Area Coordinators	@ 6,800
	1	RN	9,300
	5	Health Aides	@ 5,500
	2	Aides	@ 5,500
	12	TOTAL	
Montana Department of Health Helena, Montana	1	PHN	$10,800
	1	TOTAL	
Weld County Health Department Greeley, Colorado	1	Sanitarian	$ 4,000
	1	Dental Assistant	3,600
	1	Family Health Worker	4,200
	1	PHS Nursing Supervisor	8,700
	1	LPN	7,500
	1	Receptionist/Interpreter	2,100*
	1	Physician	12,000*
	7	TOTAL	

Page 16

PROJECT		STAFF	SALARY
Colorado State Department of Public Health Denver, Colorado	1	Program Administrator	$11,000
	1	Nursing Coordinator	15,500
	1	Registered Dental Hygienist	9,400
	1	Area Nursing Coordinator	11,400
	1	Area Nursing Coordinator	9,600
	1	RN Staff Nurse	9,600
	1	Staff Nurse	9,000
	1	Family Health Worker	7,500
	1	Family Health Worker	6,000
	1	Family Health Worker	4,000**
	4	Clerk/Typists @	4,800
	5	Staff Nurses @	9,000
	2	Family Health Workers @	4,800
	2	Family Health Workers @	6,000
	23	TOTAL	
FUND Ft. Lupton, Colorado	1	Executive Director	$18,000
	1	Health Administrator	16,000
	1	Business Manager	8,965
	1	Billing Clerk Trainee	6,300
	1	Bookkeeping Trainee	6,300
	1	Medical Director	24,000
	1	Physician	20,000
	1	Physician	22,000
	1	Nursing Assistant	6,300
	1	Staff Board Trainer	10,000
	1	Dental Assistant	6,857
	1	Dental Assistant	6,300
	1	Lab and XRay Technician	6,857
	1	Clinic Clerk/Receptionist	6,300
	1	Clinic Clerk/Receptionist Trainee	6,000
	1	Outreach Director	8,000
	6	Family Health Counselors @	6,800
	2	RNs @	9,000
	1	Driver	3,000*
	1	Janitor	5,343
	26	TOTAL	

REGION IX

Regional Office Migrant Program Employees with Spanish-Surnames 0

Number of Directors/Administrators of Migrant Projects Who Are Spanish-Surnamed 4

Bilingual Staff by Project:

PROJECT	STAFF		SALARY
Arizona Job Colleges, Inc. Casa Grande, Arizona	1	Secretary	$ 4,740
	1	Records Clerk	4,200
	1	Home Health Aide	4,200
	3	TOTAL	
Yuma County Health Department Yuma, Arizona	2	Clerk/Typists	@$ 6,180
	1	Health Aide	4,188
	1	Health Aide	4,396
	2	Community Workers	@ 3,792
	6	TOTAL	
Maricopa County Health Department Phoenix, Arizona	1	Dental Technician	$ 5,800
	1	TOTAL	
Stanislaus County Medical Society Modesto, Claifornia	1	Nurse	$ 9,875
	4	Health Aides	@ 5,500
	5	TOTAL	
University of California at Davis Davis, California	3	Aides	@$ 4,680
	3	TOTAL	
Santa Cruz County Health Department	3	PH Aides	@$ 5,700
	3	TOTAL	
San Luis Obispo County Health Department	1	Health Aide	$ 4,956
	1	Health Aide	5,952
	1	Health Aide	6,528
	1	Junior PH	11,400
	4	TOTAL	

PROJECT	STAFF		SALARY
California State Department of Health Berkeley, California	1	Administrator	$17,452
	2	Nurse Consultants	@ 17,452
	1	Translator	7,009
	1	Consultant	26,000
	1	LVN	6,612
	1	LVN	3,948
	2	Aides	@ 4,680
	9	TOTAL	
Fresno County Health Department	2	Aides	@$ 4,600
	2	TOTAL	
Sacramento County Medical Society	1	Dental Assistant	$ 6,240
	4	Aides	@ 6,240
	5	TOTAL	
Orange Cove Family Health Center Fresno, California	1	Director	$16,500
	1	PHN	11,748
	1	LVN	6,384
	2	LVNs	@ 5,640
	1	Clinical Aide	4,656
	1	Lab Aide	4,656
	4	Family Health Workers	@ 4,656
	1	Clinical Billing Supervisor	6,228
	2	Drivers	@ 5,124
	2	Receptionists	@ 5,004
	1	Medical Records Clerk	4,656
	1	Janitor	4,656
	1	Purchasing Agent	6,228
	1	Business Manager	12,000
	20	TOTAL	
Kern County Health Committee Bakersfield, California	1	Medical Director	$27,000
	1	LVN	6,658
	1	Night Watchman	5,200
	1	Secretary	5,344
	1	Secretary	5,400
	1	Community Liaison Worker	10,580
	6	TOTAL	

Page 19

PROJECT	STAFF		SALARY
Sutter County Hospital	1	Physician	$ 500*
	2	RNs	@ 10,920
	4	LVNs	@ 8,79
	1	Insurance Billing Clerk	8,299
	1	Registrar/Clerk	8,299
	1	Clerk/Typist	4,692
	2	Community Representatives	@ 5,611
	2	Community Representatives	@ 5,654
	1	Receptionist	5,644
	1	Medical Records Librarian	7,896
	1	Driver	5,344
	1	Clerk	5,654
	1	Bookkeeper	6,600
	1	Medical Records Assistant	5,344
	1	Clinic Aide	5,344
	1	Consultant	3,640*
	1	Business Manager	10,400
	23	TOTAL	
Clinica de Salubridad de Campesinos Brawley, California	9	Community Health Workers	@$ 5,400
	2	Secretaries	@ 6,000
	1	Secretary	6,300
	2	Secretaries	@ 5,496
	5	Nurses	@ 5,040
	2	Maintenance Men	@ 6,504
	2	Housekeepers	@ 4,800
	1	Eligibility Worker	5,400
	1	Medical Records Clerk	5,400
	2	Social Service Workers	@ 6,000
	1	Driver	6,000
	3	Receptionists	@ 5,040
	1	Director	17,000
	1	Assistant Director	10,000
	1	Community Advocate	8,400
	1	Billing Clerk	5,400
	1	Insurance Clerk	5,040
	36	TOTAL	

PROJECT	STAFF		SALARY
San Joaquin County Medical Society Stockton, California	2	Field Coordinators	@$ 7,500
	7	Health Aides	@ 5,200
	5	Intake Clerks	@ 3,120*
	3	Outreach Aides	@ 2,883*
	1	Secretary	4,500
	18	TOTAL	

REGION X

Regional Office Migrant Program Employees with Spanish-Surnames 1

Number of Directors/Administrators of Migrant Projects Who Are Spanish-Surnamed 6

Bilingual Staff by Project:

PROJECT	STAFF		SALARY
Whatcom-Skagit Rural Opportunity Council Mt. Vernon, Washington	2	Aides	@$ 4,800
	1	Aide/Clerk	4,800
	1	Controller	7,320**
	1	Project Director	12,672**
	5	TOTAL	
United Farm Worker Service Center Association Toppenish, Washington	1	Project Director	$17,500
	1	Clinic Administrator	10,800
	1	Business Administrator	17,000
	2	Account Clerks	@ 5,400
	1	Purchasing Clerk	5,400
	2	Receptionists	@ 4,500
	1	Asst. Lab Technician	6,600
	1	Asst. XRay Technician	6,600
	1	Asst. Optometry Technician	6,000
	2	Secretaries	@ 7,200
	24	Outreach Workers/Aides	@ 6,000
	37	TOTAL	
Wenatchee Community and Migrant Assistance Committee Wenatchee, Washington	2	Outreach Workers	@$ 4,800
	2	TOTAL	
Idaho Migrant Council Nampa, Idaho	4	Home Health Aides	@$ 4,500
	1	LPN	6,000
	1	Medic	7,200
	1	Community Health Service Coordinator	7,500
	1	Administrative Secretary	5,700
	1	Account Clerk	5,400
	1	Account Clerk	6,000
	4	Receptionists	@ 4,500
	14	TOTAL	

PROJECT	STAFF		SALARY
Valley Migrant League Salem, Oregon	1	Coordinator	$22,000
	1	Secretary/Receptionist	4,908
	1	Secretary/Bookkeeper	5,520
	3	TOTAL	
Oregon State Board of Health Portland, Oregon	13	Aides	@$ 4,980
	1	LPN	5,040
	5	PHNs	@ 8,400
	19	TOTAL	

* Part time employee
** Paid by other sources

SUMMARY TABLE

Region	Bilingual Staff			Director/ Administrator Spanish-surnamed	Regional Staff Spanish-surnamed
	Upper Level Professional & Administrative	Mid Level Professional, Technical and Administrative	Para-Professional and Supportive		
I	3	4	15	2	0
II	5	6	20	2	0
III	2	6	2	1	0
IV	11	6	24	1	0
V	22	30	107	4	3
VI	8	34	79	14	1
VII	1	9	7	1	0
VIII	9	22	38	3	3
IX	12	22	110	3	0
X	6	37	37	6	1
Central Office TOTAL	79	176	439		

Migrant Health Branch 5 Professional Employees 1 Spanish-surnamed

Senator KENNEDY. Our second panel of witnesses includes two individuals familiar with the plight of the migrant and seasonal farmworker and his family. Both come from the valley of southern Texas. They are Leo Garza, director, Hidalgo-Starr Catholic Charities; and George Powell, senior supervisory attorney, Texas Rural Legal Aid, Edinburg, Tex.

Both can tell their experience with health care problems with migrants.

You can proceed in any way you like.

STATEMENT OF LEO GARZA, DIRECTOR, HIDALGO-STARR CATHOLIC CHARITIES, PILGRIM HOUSE, SAN JUAN, TEX., ACCOMPANIED BY GEORGE POWELL, SENIOR SUPERVISORY ATTORNEY, TEXAS RURAL LEGAL AID, EDINBURG, TEX.

Mr. GARZA. I am just going to read my testimony.

Senator Kennedy, members of the Senate Subcommittee on Health, I am Leo Garza, Jr., resident of San Juan, Tex., presently employed by the Diocese of Brownsville as director of the Hidalgo-Starr County Branch Office of Catholic Charities.

My involvement in the health field has been in the area of consumer advocacy and the organization of consumer boards and committees. It was reassuring to read in the Federal Register, provisions for some degree of participation by the consumers of health services.

Gentlemen, I am sorely tempted to use strong rhetoric in presenting the abhorrent conditions which affect the minds and lives of the people whom I have been asked to represent. But knowing the thick skins that people in your field are forced to wear and knowing that figures and numbers are not always bad words and oftentimes easier for some people to relate to than stark human misery, I will share with you a few of them in hopes that you can understand that these numbers represent mothers and fathers and many, many innocent brothers and sisters.

Most of the figures I will use are drawn from my area of Texas which houses the largest and most populated migrant base in the Nation. Please keep in mind that the very real people that these figures represent help feed and keep the rest of this Nation wealthy and above all healthy.

The Lower Rio Grande Valley is a three-county area at the bottommost part of Texas, bordering the northern part of Mexico. The counties, Hidalgo, Cameron, and Willacy, cover a total of 3,019 square miles with a combined population of 337,473 of which close to 130,000 are migrants and seasonal farmworkers. About 58.1 percent of the families earn less than $5,000 and 36.8 percent earn less than $3,000. The average migrant family income is $2,000. The average size of a migrant family is 6.7 people, which means that the average family member has $298 per year with which to survive.

There is no way possible for a man to provide the necessary health care for his family, which too often he sees not as a human right but as a luxury, too far out of reach. After speaking to people involved in the health field and people directly affected by the present conditions or health care, these are the areas of major concern: Maternal and child

health, hospitalization, dental, sanitation—water—nutrition, and medical manpower.

As you can well imagine, I do not have figures that indicate that the problem is one of overabundance.

MATERNAL AND CHILD HEALTH

The following are selected vital statistics, 1970, from Willacy, Cameron, and Hidalgo Counties.

Do you want me to read these?

Senator KENNEDY. We will include all those in the record. You can sort of draw from it a bit when you compare the conditions of infant mortality with the Nation as a whole. Just draw from it, but you do not have to read it.

(The information referred to follows:)

SELECTED VITAL STATISTICS (1970) FROM WILLACY, CAMERON AND HIDALGO COUNTY

Births	Total	Percent
Live births (Total)	10,170	100.0
Delivered by physician	8,103	79.7
Delivered by midwife	2,067	20.3
Delivered at hospital	7,958	78.2
Nonhospital deliveries	2,212	21.8
Nonhospital nonmidwife	145	1.4
Premature deliveries	584	5.7
Deaths (total)	493	
Fatal deaths	150	
Maternal deaths	3	
Neonatal deaths	136	
Infant deaths	204	

Mr. GARZA. I do not have the number of midwives we have serving the population, but many of our people, especially migrant people, have to go to midwives and the midwives are not properly trained, therefore, they do not deliver proper services. Hence, we have a high infant mortality rate.

I would like to cite a personal incident at this time. I recently entered a house in the small town of Progreso. The mother had just undergone a delivery by a midwife, and she had her son with a bandage around its umbilical cord and waist. She had put some sort of salve on it. She said the midwife told her to put salve on it.

She had it wrapped up so there was no air. It was putrid. We took the bandage off and sent her to the migrant health clinic. It was about a week before the child was normal again. It had sores all over its body, and I do not know whether it resulted from the improper medical care, but this is not uncommon.

At present there are several non-Federal and Federal programs providing prenatal and postnatal care, though these programs have met with little success because none of them provide delivery services, and because many Chicano mothers are not aware of the dangers of inadequate prenatal and postnatal care.

Another horrendous fact is that each year approximately 700 mentally retarded children are born due to the lack of prenatal care in the three-county area.

HOSPITALIZATION

In the area of hospitalization and availability of health manpower, the valley again falls on its face. There are a total of 775 hospital beds in the three-county area which gives us approximately 2.3 beds per 1,000 population while the national average is 8.2 beds per 1,000 population. We have 77 doctors per 100,000 population, while the national average is 123 doctors per 100,000.

In the three migrant project clinics now operating in the Valley, we have three full-time physicians which gives us three doctors per 100,000 migrant population.

The Hidalgo County migrant health project was granted a total of $7,000 last year for hospitalization. Taking the average cost per patient hospitalization of $396—$160 for doctor and $209 for hospital—the project could hospitalize an average of 14 migrants per year.

Senator KENNEDY. Are those three doctors Spanish-speaking doctors?

Mr. GARZA. One of them is.

Senator KENNEDY. How old are they? Are they younger men——

Mr. GARZA. We have one lady doctor in her early 30's. The male doctor, who is a Mexican—born in Mexico, is in his 40's, and the other doctor, I am not sure.

Senator KENNEDY. Are they going to stay? Do you hear anything about them moving out?

Mr. GARZA. They are not under contract. That is one of the problems we have. Because they are not under contract, oftentimes they leave early and they arrive at the clinic late and take 2- or 3-hour lunch breaks. They have patients in the hospital that they visit during working time, and they are paid a salary to be there from 8 to 5.

Senator KENNEDY. They have their own private practice besides clinic practice?

Mr. GARZA. One of the doctors in the clinic is an anesthesiologist, and he does his hospital rounds in the morning before coming to the clinic.

Senator KENNEDY. This sometimes raises problems on what they receive as a salary from the clinic, and raises problems on the whole question of quality of care.

We find in many parts of the country that some doctors who work in a health center have private patients, and they are more inclined to give a little better attention to private patients. If the two get sick at the same time, there is more incentive to go to the private patient rather than the one in the clinic; and this is a problem. That is why we say most of the physician's work has to be in the health center. We do not make it exclusive, but it ought to be predominant; otherwise, I think it raises some very basic conflicting problems.

Obviously there has to be a greater flexibility in rural communities and remote areas where you do not have a lot of doctors. Still it is a problem and it is one that you are mentioning here, one which we are sensitive to.

Please continue.

Mr. GARZA. The availability of health care becomes even more difficult during the winter months when the migrants are here at home base.

Every year, the Valley Chamber of Commerce estimates an average of 50,000 winter tourists, called snowbirds, migrate from the northern snow States to bask in our mild climate. These retirees bring with them their own health problems.

Then we can figure in an additional estimated 50,000 legal aliens from Mexico and it is easy to see how the overload on existing health facilities is staggering and the people most staggered are the migrants and their children.

Dental services for migrants in the valley are practically nonexistent. The migrant programs have not been funded or have been unable to implement effective dental services due to insufficient funding.

Senator KENNEDY. Do you have natural fluoride in the water down there?

Mr. GARZA. I have no idea.

I am going to present these figures to emphasize the lack of availability of dental care in our area.

The national average is one dentist per every 1,683 population. The Texas average is one for every 2,395. The valley average is one for every 6,830.

The buying income per capita of our people in the valley is 1,470, as compared to the national average of 3,078.

I give these figures to show how difficult it is to purchase the luxury of dental care for some of our people in the valley. This is the valley average; not migrant average.

Senator KENNEDY. What is the migrant average; about the same?

Mr. GARZA. I have not figured that. It is substantially lower when you take average income, where 38 percent of the population earn less than 3,000, the average migrant income is $2,000.

Of the almost 300,000 migrants in Texas, it is estimated that 93 percent of the total migrant population need dental services. Last year, only 1,395 migrants received any kind of dental services. At present, and only on a very limited scale, only emergency dental services—relief of pain and infection—are available. There are no restorative services.

SANITATION AND WATER CONDITIONS

In a speech presented by Representative Eligio de la Garza to the House of Representatives, Wednesday, April 7, 1971, he was quoted as saying:

> There are many settlements—some called colonias in my area—that have no facilities at all or sewerage disposal—and no reasonable expectation to secure any under the existing programs which are in the major part, limited to cities and towns or at least incorporated areas.
>
> It is a shame to have to tell you that we still have many of our citizens in my area who must drink water from irrigation ditches and canals. Many must carry water in tanks or barrels for miles to have any water in their homes.

This is true. A while back, I worked in the colonias, and I saw mothers and children going out to the backyard to the canals with buckets in their hands bringing in water for home use.

On the other side of the canals are fields which are periodically sprayed with insecticides by the farmers who grow cotton and other crops on the land. So undoubtedly a lot of these insecticides get into the water and cause quite a bit of physical harm. It is unsavory, if nothing else.

Senator KENNEDY. I would think taste is the minimum qualification.

Mr. GARZA. Precisely. These figures were taken from a study done by Colonias Del Valle under an OEO grant—1971.

Total number of colonies with water, 27; total number of colonies with no water, 45; total number of families in these colonias with water, 3,029; total number of families in these colonias with no water, 3,125; total population in the colonias with water, 21,203; total population in the colonias without water, 27,475; and total number of population in all the colonias, 48,678.

The Public Health and Nutrition Education Subcommittee did a study, and I have included a copy of the summary of their findings. It shows a substantial deficiency of vitamin A, 51 percent among migrant children in the valley, which is very ironic in that we have thousands of acres that produce vegetables which are very rich in vitamin A.

There is also a deficiency in vitamin C. The whole valley is covered with oranges, all kinds of citrus fruit.

I would like to move on now. I have included some graphs done by health planning region 10 in the lower Rio Grande Valley. They did not break it down to the lower Rio Grande Valley, but it is south Texas, which covers 20 to 22 counties.

You can see by the graphs south Texas far surpasses, although it is nothing to brag about, the rest of the Nation and Texas, in the incidence of disease. The diseases are listed here.

(The information referred to follows:)

Public Health and Nutrition Education Subcommittee, May 1972

Summary of
Nutritional Problems in
The Lower Rio Grande Valley

Recent studies by the University of Colorado (UCMC) on Migrant Nutrition (1970-72) and the Texas Nutrition Survey (TNS) in 1968 and 69) of low income families as well as the 1965 National Household Survey (NHS) give information concerning actual and probable nutrition problems in the Lower Rio Grande Valley. For example:

STATUS

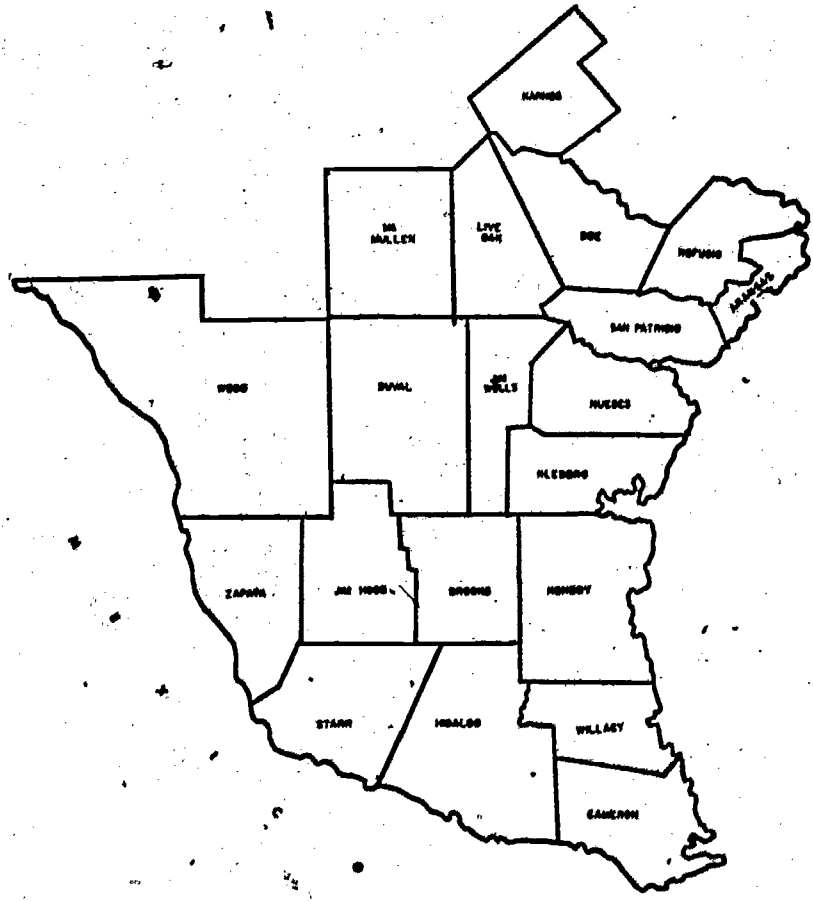
Vitamin A:
51% deficiency among migrant children (UCMC)
Insufficient Vitamin A in 17% of total population (TNS)
Deficiency is twice as prevalent among Mexican-Americans as Anglos (TNS)
Lack of Vitamin A is correlated with low income and low educational level
Vitamin C:
Incidence of deficiency ranges from 3.5% (UCMC) in Hidalgo County children to 20% (TNS) in State.
Iron:
6% deficiency (UCMC) and 26% (TNS) indicated
Vitamin D, Calcium:
UCMC showed 6-13% deficiency in the first 2 years of testing; bowed legs are common.
General: Growth patterns indicate 42% of children fell below the 5th percentile compared to the 5% considered normal (UCMC). High TB rate is related to inadequate diet and housing (NHS). Diabetes accounts for 5.5% of new patients at Migrant Health Clinic each month. TNS suggests 40% of adult women and 20% of adult males are overweight.

SOLUTIONS

Develop an educational campaign through mass media and personal contact.
Saturation campaign to increase awareness of importance of diet in maintaining health via:
Media--Bilingual radio, TV, newspaper, and other printed matter,
Handouts--food stamp distribution points, grocery stores, schools and
Personal Contact--individual, group.
Long term program--continue to reinforce education for good nutrition.
Develop a resource center to correlate, implement and plan programs from media campaigns to research.
Obtain coordinator of school nutrition education programs through Region I Education Service Center*.
Assist with Food Stamp Program.
Improve school, * institutional and public restaurant menus.
Improve menus in homes with working mothers.#
Continuously assess needs and progress through behavioral and clinical observation and research.

REGION 10

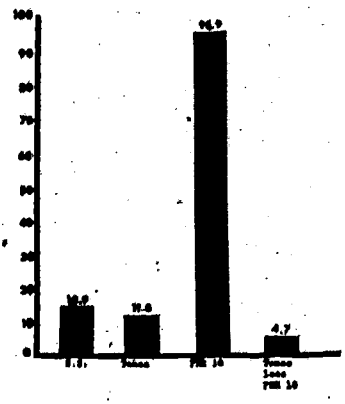
TEXAS STATE DEPARTMENT OF HEALTH



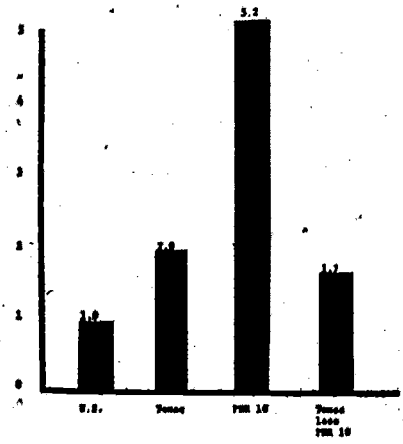
84-852 O - 72 - 4

Comparative Incidence of Communicable Diseases
U.S., Texas and Public Health Region 10
(1970-71 Average)

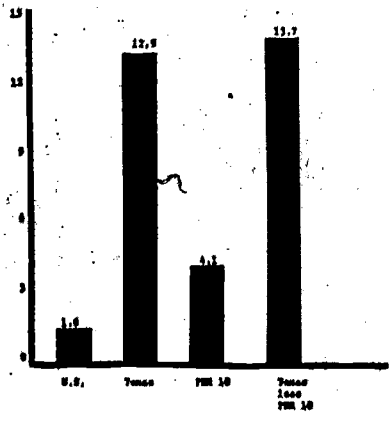
AMEBIASIS



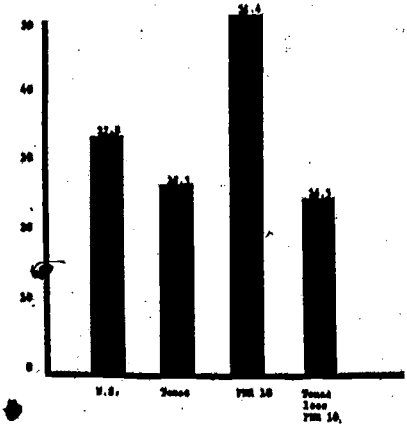
BRUCELLOSIS



DIPTHERIA

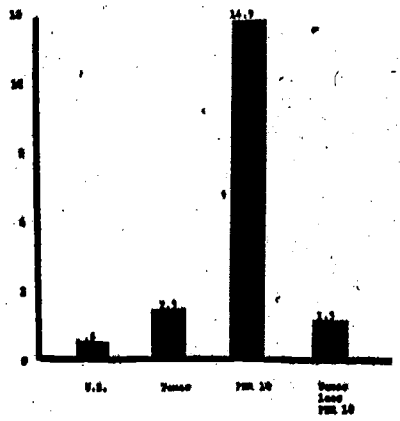


HEPATITIS

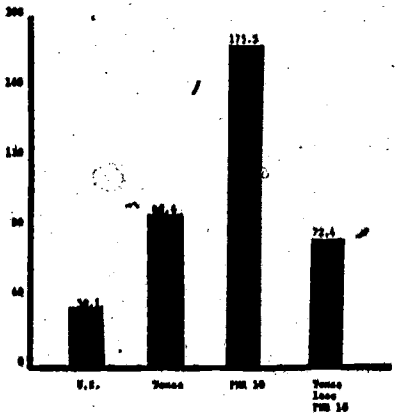


Comparative Incidence of Communicable Diseases
U.S., Texas and Public Health Region 10
(1970-71 Average)

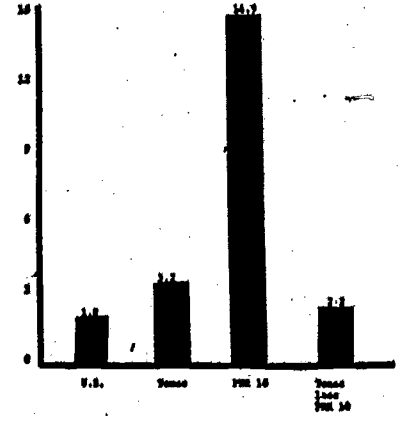
LEPROSY
(Rate per 1,000,000)



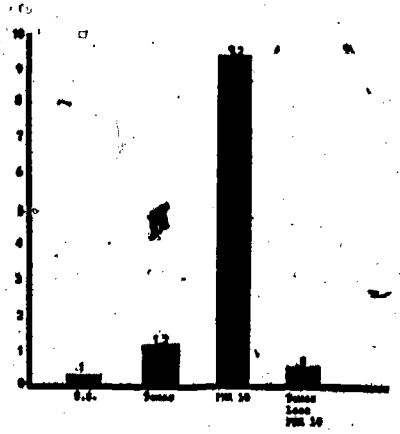
MEASLES
(Rate per 100,000)



PERTUSSIS
(Rate per 100,000)

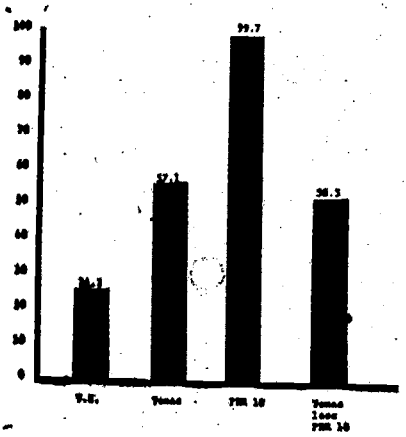


POLIO
(Rate per 1,000,000)

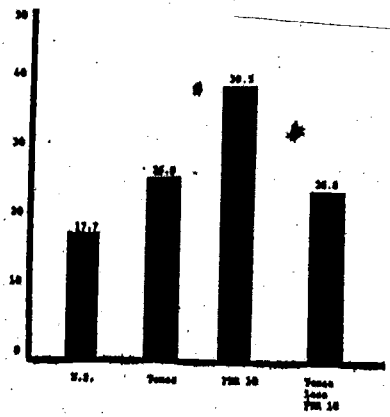


Comparative Incidence of Communicable Diseases
U.S., Texas and Public Health Region 10
(1970-71 Average)

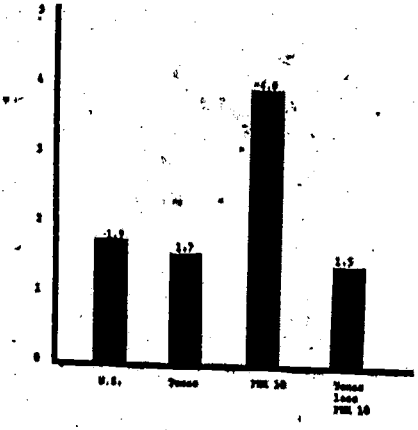
RUBELLA



TUBERCULOSIS

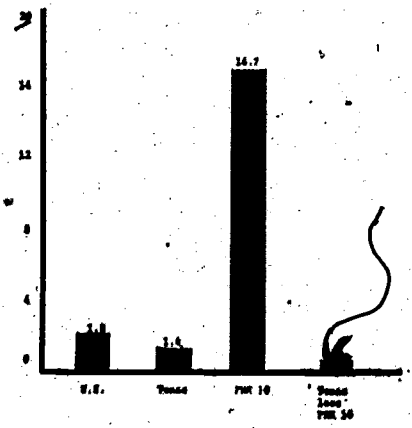


TYPHOID

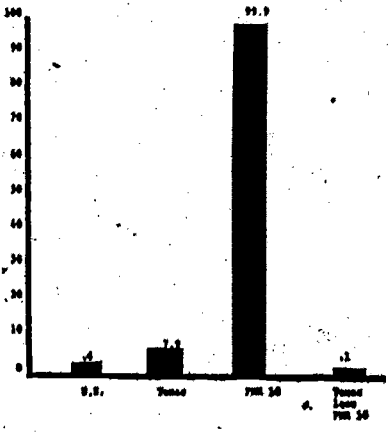


Comparative Incidence of Communicable Diseases
U.S., Texas and Public Health Region 10
(1970-71 Average)

TYPHUS
(Rate per 1,000,000)



VER
(Rate per 1,000,000)



Mr. GARZA. I would like now to relate to you a story about two women who had not seen each other for many years and now find themselves together in a bus. Woman No. 1 is relating her success in marriage, and how she and her husband travel abroad every year, and how her home in the suburbs has a three-car garage, et cetera. At periodic intervals woman No. 2 exclaims, "fantastic."

After half an hour of this woman No. 1 asks woman No. 2 about herself. Woman No. 2 says that she went to a real ritzy college and learned all kinds of real ritzy things such as saying, "fantastic," instead of saying, "baloney."

Now I would like to quote from the Federal Register, Department of Health, Education, and Welfare, dated May 25, 1972, volume 37, No. 102, page 10647.

Section 56.106 project elements: (a) An approvable application must provide: * * * (3) That the project will deliver or arrange for the delivery of family oriented primary health care which shall include but not be limited to:

(i) Ambulatory patient diagnosis, treatment, and followup care for acute and chronic condition;

(ii) Preventive, maternal, child health, and family planning services integrated into the delivery of treatment services;

(iii) Emergency medical and dental care; and

(iv) Diagnostic, preventive, and basic restorative dental care.

* * * (5) That the project will arrange for:

(i) Referral of complex, difficult, or unusual cases and adequate followup to insure continuity of care;

(ii) Hospitalization of patients and hospital staff privileges for project physicians; and

(iii) Transportation if required for patient care.

(9) That the project shall provide and implement methods of evaluating the performance of activities being carried out under the grant to assure that such activities are carried out in accordance with the regulations of this part.

(b) An approvable application must also include the following elements unless the Secretary determines that the application has established good cause for their omission.

(1) That in developing and operating the project, arrangements have been made for the provision of the following ancillary services; nutrition, respiratory disease care, accident prevention, environmental health services, and health and sanitation education;

(2) That paramedical and allied health professional personnel have been or will be employed by the project; and

(3) That a plan for education of the population to be served as to the availability and location of supplemental health facilities and services has been or will be developed. Fantastic. Like woman No. 1 these things are great to have and dream about. It is even good to write them down, but to expect people to believe in them? "Fantastic."

I really question whether HEW or anyone else connected with migrant health really expect the field programs to carry out these mandates under their present funding or even under the proposed new level. Can we expect sufficient corollary moneys for hospitalization, immunization, dental care, sanitation, maternal and child care, and

personnel to implement these projects? Or, should we just exclaim "fantastic," and write it off.

The people I represent cannot afford for me to do this and I as a human being must fight for the welfare of a people which is theirs as a human right. I wish that it were possible for me to transport this committee to the tragic valley so you could see with your own eyes the families wracked by disease and sores; so you could drink the water they drink from canals and experience the degradation they feel when your own fecal matter is floating around your feet during flood season.

This is why, what some people call the Magic Valley, our people call it El Valle de Lagrimas—the Valley of Tears.

Senator KENNEDY. Very fine. Very good testimony. Very helpful.

I wish we could go down, too. I was down in 1965 or 1966 with Senator Yarborough.

Would you describe the new consumer board?

Mr. GARZA. Migrantes Por Salud was started a little over a year ago. I was not around at the time, but they went through a very slow process. It is hard to build up credibility if you are a migrant group. But they eventually became the only formal, migrant consumer or indigent consumer group in the county. It seems the establishment read the writing on the wall as to the new regulations, so they started making little headways with our group, and we were asked to seat 51 percent on the Hidalgo County Health Care Corp. which is comprised of a representative from the medical society, a representative from the pharmaceutical society, a representative from the nurses, a representative from the churches—Texas Conference of Churches—a representative from the Student Center for Social Involvement, and we have five representatives, and it is made up predominantly of migrants, representatives of the poor, and they have made some headway.

The Hidalgo County Health Care Corp. now administers the migrant health project funds, and we have also been able to bring two model cities clinics under our wings.

Senator KENNEDY. Why do you think a consumer based project would be more effective than those sponsored by the county medical department?

Mr. GARZA. Mainly I feel that, well, I am involved in a people movement, and until the people decide to take the initiative and start controlling some of these programs that are brought down from Washington, then it really is not a people movement, it is a Washington movement pushed on the people, and the reaction by some of the people in the community, the consumers, is one of distrust. I feel that if the people do control the programs, that the services provided by the programs will be easier to receive and maybe a little more humane in their presentation of services.

The migrant health program in Cameron County of which Catholic charities is the grantee, has an administering board, Organizaciones Unidas, which is a group comprised of representatives from about 20 grassroot, migrant oriented organizations. The county health program was in charge of the migrant health funds before we took over the program after Organizaciones Unidas started—their patient turnover grew to something like 50 to 60 per day, which is unheard of, and which was unheard of under the county control. They have also in-

stituted some innovative programs which are a maternal child care program that is run by a nurse midwife. She is giving prenatal and delivery services, et cetera, which we are trying to incorporate into Hidalgo County. We have not had much success yet.

Senator KENNEDY. What does medicaid do for you down there?

Mr. GARZA. I am not at all familiar with medicaid, I am sorry.

Senator KENNEDY. Probably because it does not do very much.

Mr. GARZA. That is probably one of the reasons I am not familiar with it.

Senator KENNEDY. Tell me, just finally, we are trying to arrive at some appropriations figures, and we started off with $100 million for the first year. Could your program down there effectively use that money in alleviating some of the health needs of the people? What could you tell us about the budget needs of the community?

Mr. GARZA. We could use $100 million in the valley alone. You saw some of the statistics. They are staggering. They are not going to remedy themselves.

It does not matter how many proposals we get unless we have the corollary funding to implement the programs, and the programs are going to have to be very innovative to deal with the particular problems that we have amongst the migrants in the valley. But if you had $100 million, I would apply for all of it.

Senator KENNEDY. We are going to try and get it. We are going to hear now from Mr. Powell.

Mr. POWELL. My name is George Powell. I am an attorney with Texas Rural Legal Aid Inc., which covers a 10-county area in south Texas.

I have been asked to comment on migrant health problems in the Rio Grande Valley and to give examples of the difficulties that migrant workers and indigents face. My statements will be directed at only one aspect of the migrant worker's general health problems, his inability to obtain medical treatment.

Because I am an attorney, my contact with the health problem is usually in the way of the client coming to me after something has been done to him that denied him, say, proper medical treatment.

On my written statement, I have one example. If you wish to question me as to other examples, I have personally been privy to numerous situations in which people have been deprived health care, and where this deprivation has resulted in death of one person or more.

None of the hospitals in the valley provide outpatient facilities or care. By this I mean a person does not walk into a hospital and receive treatment for something such as an emergency accident injury, a car accident.

The hospitals do not maintain regular staff physicians nor do they participate in any residency or internship programs. That means there is not a regular medical staff on call in the hospitals at all times. All doctors associated with the hospitals are private physicians who admit their patients desiring hospital care. To be admitted, the patient must pay $150 deposit, or sign a promisory note if he cannot show coverage under some kind of insurance plan or policy, regarldess of his income or ability to pay.

Senator KENNEDY. Is that in all the hospitals?

Mr. POWELL. Yes.

Senator KENNEDY. Is it all the same amount?

Mr. POWELL. $150 for each hospital. This is regardless of income or ability to pay.

Senator KENNEDY. Is that just for migrants or other people?

Mr. POWELL. That is for everybody. If he has medical insurance, he does not have to.

Senator KENNEDY. What is the first thing they ask you? How sick you are or whether you have $150?

Mr. POWELL. Whether you have $150. Well, that is, as in one example I will give you, they ask two things first: $150 is the first thing, and if you do not have it, they hassle with them for awhile and they get the individual to sign a promissory note to the hospital. If the migrant worker or indigent is unable to pay his bill, the hospitals seek to collect on the promissory note. After the hospital has paid, the notes are almost always turned over to a collection agency to collect.

The collection agency usually will use any means possible to collect. They threaten with lawsuits. Oftentimes you end up having attorneys who work for the collection agency or the hospital attempt by writing letters threatening suits to collect on the notes. This is done as a matter of course, regardless of the income of the individual. Every hospital in the Rio Grande Valley is almost completely built on the Hill-Burton funds. They sign a contract with the Federal Government, through State distribution agency, to provide a reasonable amount of indigent care, although none of them have programs for providing any indigent care whatsoever. A few clinics do now exist, as Mr. Garza mentioned, that provide indigent care, but the problem with these is there is just usually one physician attached to each clinic. Most of the migrants or poor people in the valley do not have personal physicians; because of lack of personal funds, they are so poor that they cannot afford regular visits to the doctor; also, general distrust and fear of doctors. There are many examples of poor health, one of which I will mention here which is in my written statement, involves a couple who visited my office one morning last fall. The wife was pregnant, in labor, and had been refused admittance at the hospital in Edinburg, Tex., a town in the valley.

They were denied aid because they did not have a doctor to request she be admitted. Because there is no permanent medical staff in these hospitals, another prerequisite for admittance is that each individual must be admitted by a private physician. Not only do they have a deposit problem, they have to have a doctor notify the hospital that they should be admitted.

This particular couple here did not have a doctor in this area, partially because they were poor probably and could not afford one, and they were also from a town outside Edinburg about 100 miles from there, and they had come to Edinburg to work in the fields, because there was no work in the area from which they came.

I called the hospital after they were in my office and asked them why they were denied admission to this hospital. The hospital informed me that no one is refused admittance. My response to that was, "———, I have a lady in my office who is in labor and was refused a few minutes ago."

The hospital administrator then checked the incident and informed me that the patient must have an admitting physician. After further discussion, the administrator agreed to admit the prospective mother if she returned to the hospital. Unfortunately this was not the end of the difficulty. About 2 weeks after this incident, a private attorney specializing in personal injury litigation came to my office to discuss the matter with me. When the couple returned to the hospital, they had again been denied admittance despite the administrator's assurances to me. The couple then sought out the services of a midwife who stayed with them until late in the evening. This was until about 11. They came into my office about 11 in the morning. They were again refused, finally refused admittance to the hospital at approximately 2:30. They went to the midwife and were with the midwife until about 11 that night. At 11 that night the midwife realizing that this was not a regular birth, it was something abnormal about it, notified the local physician—this was approximately 11 that night—that she had a problem. They described the problem to the local physician who then called the hospital and told them to admit this woman. At 11:30 she was admitted. Both the lady and baby died at about 2:30. This was 15½ hours after they had tried to get into the hospital.

I do not know whether both of them or either one of them could have been saved, if she had been admitted immediately, but I would think that given medical treatment as it should be, that one or two or both of them could have been saved. But nevertheless it took them 12½ hours to get into the hospital, and 15½ hours later both mother and child were dead.

I think this is an example of just one, and there are many, of how a person being denied effective use of medical facilities, the few that there are—there are very few medical facilities—but even to be denied the few that there are in the valley results in such incidents as this.

This is one, and if you would like other examples, which I do not have in my written statement, but I have got many.

Senator KENNEDY. What is being done, if anything, to prevent this from happening again?

Mr. POWELL. Just as to indigent treatment of hospitals, myself and other attorneys on the staff, we are working on a suit against all hospitals, and maybe one hospital in particular which handles most of it, that will try and force them—we feel we can win it—force them to provide some sort of indigent care, meaning they are going to have to live up to their Hill-Burton obligations, but that would not affect this situation. Because the hospitals are still going to have a tendency to turn the people away.

They are still going to say where is your doctor, if they do not have a doctor, and people are still going to have to hassle with the hospital to get in.

Oftentimes the problems that individuals have, like I will give you another example that shows another problem: one of the first cases I had when I became a lawyer for the Texas Rural Legal Aid, about a year and a half ago, when a grandmother came in because her son who is the father of this child worked for a city in the valley that it was at that time considered to be quite repressive. He was afraid to do anything himself. The grandmother had taken her grandchild,

3 months old, to a hospital. The grandchild had pneumonia eventually. The mother took the child there three times. It was denied entrance three times. Finally she did get in touch with a physician, and the child did have a physician, and he informed the hospital that they should let the child come in. This was after three attempts to get into the hospital.

Then the grandmother took the 3-month-old baby back which had pneumonia. The hospital admitted the baby, and they put the baby in the emergency room. No doctors or nurses treated the child when she was in the hospital. The child was throwing up all over itself, choking and gagging, and the only one who cared for the child was the grandmother.

The child was there about an hour and a half and it died. She could not get nurses or doctors to care for the child. A suit based on Hill-Burton obligations is not going to cover this kind of treatment. It is not going to make doctors who are available or make nurses in hospitals give the kind of care that poor people as human beings should have.

Many of the situations, incidences that adversely affect the poor people in this area come after the children or the people have been tentatively admitted to the hospital or have in some way tentatively received some sort of medical treatment. The doctors, the nurses, the hospital administrators are not responsive in any way to the poor people, the problems they have. They are not responsive to them as human beings. They are generally ignored when they go into hospitals. Physicians do not take them seriously as they would a wealthier person.

Worse than a physician, of course, I think are the nurses, just general hospital staff which have a tendency to completely ignore the poor person once he has entered into the hospital. When I speak of poor people, and in the valley poor people and migrants are almost the same. because most of the people in the valley that are poor either have been migrants recently, or at present, or are going to sometime in the very near future. It is a migrant population. It would be very difficult there to distinguish between, say, the stationary poor and the migrant poor, because most of the people—well, there are so few jobs that eventually someone in order to work is going to have to migrate, if you are a poor and uneducated person in the valley.

Senator KENNEDY. Tell me, do you know of instances where there has been harassment of either migrants or the seasonal workers, when they left the hospital, they did not have the money to pay the bill?

Mr. POWELL. Yes, this happens regularly.

Senator KENNEDY. Tell us about that.

Mr. POWELL. This is standard treatment. Well, mainly, it is the hospital that sends letters threatening to turn it over to an attorney or collection agency. The major hospital in the valley is sort of a general hospital for the county and this particular hospital takes the prommissory note that it usually gets the people to sign, because the people do not have money to, say, pay $150 deposit. They take the prommissory note and they either sign it to a bank or to a collection agency in San Antonio. The bank or the collection agency will mail them—the collection agency has notices, and they are especially designed to scare, especially an uneducated person, who usually does

not read English and has to have someone read it to them. The notice will be big, and it will have big letters saying something like "Final Notice before Suit. If you do not remit the amount listed below, this will be turned over to our attorney and a suit will be filed immediately."

They used to leave out the part that it will be turned over to our attorney, but they were sued and they had to stop threatening suit in their own name. That is fairly common practice. It starts off maybe one a month down to one a week, and more frequently than that until they either determine that people absolutely will not pay or that they cannot pay, and they just figure they will drop it. That is when the hospital writes it off as indigent care.

The major hospital in the valley operates at a profit, which is another unusual thing, because there are very few hospitals which operate at a profit. This particular hospital, I do not know the exact amount that it made in profit last year, but it is operating at a slight profit.

That sort of denounces the idea of charitable institution, since it does not give out charitable services and facilities and at the same time make a little money on the side.

The other hospitals in the county do not turn over to collection agencies—they do turn over to private attorneys, who attempt to collect notes through letters and notices which say, "Pay immediately or you will be sued."

Senator KENNEDY. Have they garnished any of the workers' salaries?

Mr. POWELL. There is no garnishment of wages in Texas. Also about everywhere, prejudgement, repossession of anything, has been pretty much found to be unconstitutional. There is no garnishment of wages in Texas.

In this respect, a person's home, car, furniture, salary, cannot be attached for any reason whatsoever.

Senator KENNEDY. Perhaps you could submit for us some other examples; could you do that?

Mr. POWELL. OK, just a few. The last situation, which I was personally involved in, this was about two and a half months ago, a client of mine who has been a client of mine for quite a while called me on the phone and told me that her brother and sister-in-law had recently had a child die in the hospital in Weslaco, Tex., and she asked me if they could come by and see me. I said yes. They came by that afternoon. What had happened with this child was somewhat similar to the incident I last mentioned.

The child also had pneumonia. The day before the child died, the couple took the child to a physician. This physician that they took it to happened to be one of the physicians that is there to treat the indigent people in this area. He gave the child slight medication and told them to leave, that there is nothing really wrong with the child. In early evening, late afternoon, the child was no better, so they tried to get in touch with the physician again. He talked to them on the phone and told them nothing to worry about, nothing wrong with the child. Later that evening they tried to take the child to the hospital.

There was again no admitting physician. They went on all through the next day. The next day they took the child back to the physician that they had previously seen. He went through the same thing they had gone through before, gave the child some medication and told them not to worry and that there was nothing wrong with the child.

Later they called back, they called back the physician later that afternoon and repeated to them that the child was not getting better and the medication was doing no good. He became very angry and told him not to bother him any more, that there was nothing wrong with the child. About 10:30 that evening the child was having trouble breathing, and they took the child to the hospital where the child was admitted. They signed a promissory note for $150. The child was put in the emergency room; and as in the other situation, it was not cared for. For approximately 1 hour no physician or nurse gave the child any attention whatsoever. This was about a 6-month-old baby, and the baby died about 11:30 that evening.

Senator KENNEDY. Just write down your examples and give us as much information and detail on them as you can.

Let me ask, do you have any incidents where any of the administrators refused to give back, say a newborn baby to the mother until the parents paid the bill?

Mr. POWELL. That used to happen, but the public even in the valley was a little appalled at that, so they had to stop that. I still get people who come to me saying we cannot get someone in our family out of the hospital until we pay the bill, what shall we do? I usually ask, how do you know? Have you tried to leave? They said no.

Go ahead and leave, and if anyone gives you any trouble, call me. That is an example.

It was not so long ago that it was like that. Now people in the hospitals, while they are in the hospital being cared for and are sick, are still hassled about the bill. I had one lady in the hospital recently and every time she would get up to go to the bathroom, she would come back and find a bill was on her pillow. This went on far about 3 days and she left. The administrators would come in and question her about the bill.

I believe she had a hysterectomy and was not feeling so good. They do not detain people in the hospital, as we explained to them. They cannot have a lien on your body.

Senator KENNEDY. Thank you very much. Our next panel consists of Adon Juarez, project director, Orange Cove Clinica de Salubridad, Orange Cove, Calif., accompanied by his business manager, Nick Fedan; Mr. Johnny Johnston is a board member, West Palm Beach migrant project, Belle Glades, Fla.; Mr. Ventura Huerta, project director of migrant clinic in Brawley, Calif.; Miss Olga Villa, University of Notre Dame, South Bend, Ind.

Would you care to come forward. Senator Cranston had wanted to be here for your testimony to welcome you personally, but he is unable to do so; so he asked me to extend a warm welcome to you. He has read your testimony and is delighted with your observations and recommendations that you are making.

STATEMENT OF ADON JUAREZ, PROJECT DIRECTOR, ORANGE COVE CLINICA DE SALUBRIDAD, ORANGE COVE, CALIF., ACCOMPANIED BY NICK FEDAN; JOHNNY JOHNSTON, BELLE GLADES, FLA.; VENTURA HUERTA, PROJECT DIRECTOR, CLINICA DE SALUBRIDAD DE CAMPESINOS, BRAWLEY, CALIF.; AND OLGA VILLA, UNIVERSITY OF NOTRE DAME, SOUTH BEND, IND.

Mr. JUAREZ. The migrant health program is an example of a program in crisis. There is the crisis of need, the need of the seasonal and migrant farmworker for adequate comprehensive health care services. There is the crisis of reaction unleashed with the introduction of innovative approaches to the provision of medical care, and there is the crisis of politics which often seems to be a cruel mechanism for denying aid to those who most need it. I would like to address myself to the specifics of these crises. I would like to relate on a very personal and very real level the experiences of the migrant health projects in Brawley and Orange Cove, Calif. The needs of the seasonal and agricultural worker have been documented, photographed, painted, demonstrated, demonstrated for and demonstrated against, and in general made very specific public knowledge. I can do nothing to add to those awesome statistics which list the miserable conditions under which we ask a specific segment of our population to live. I can only help to humanize it by saying that in the crisis of need we are continually asked to respond to an ever-increasing demand for service, in an area where service has been diminishing.

The seasonal farmworker, the rural poor, and the migrant farmworker are faced with a crisis not of their own making. They do not dictate that the processes of education lead to the establishment of medical schools and sophisticated centers in urban areas, as opposed to rural areas. These are all responses to the economic pressures related to the provision of medical care. Thus they are the victims not only of their own poverty, but of the poverty of resources in the rural area. If it is necessary to document the crisis of need, we may do so by referring specifically to the fact that in the first year of operation, both centers were to enroll a minimum of 500 families in each center. In the first 18 months of operation we enrolled over 3,800 families, or almost four times as many as we had projected. To give you some specific information about some of the families we serve I would like to point out the following: In a recent survey of 1,852 families who receive services from the Orange Cove center the following profile emerged: 392 are Medi-Cal beneficiaries; this is the State of California's title IXX program; 67 of the families are eligible for benefits under medicare; 131 of the families are members of the Farm Workers Union, and therefore are covered by the Kennedy plan, the union's health insurance named after the late Sen. Robert Kennedy. Other insurances cover 96 of our families. This leaves us with 1,170 families that we are currently serving that have no form of insurance; 63 percent of the families that we serve are not eligible for benefits under any of the existing plans provided for through legislation.

Some local health providers in the area will not accept the Kennedy plan as a form of payment. Gentlemen, this is not my statement; this is the statement of a vice president of the union and other members of the union, one of whom is chairman of our board.

Thus, there is a definite and positive need on the part of the community for the categorical funding of programs. The development of specific projects which are responsive to the needs of the community are necessary; and more extensive programs are required. It is clear that under the present funding levels the programs will not achieve the goal of developing appropriate health care for seasonal and migrant farmworkers. The need is tremendous, the resources with which to meet these needs, exceedingly limited.

Senator KENNEDY. Why will they not accept the Kennedy plan?

Mr. JUAREZ. They think it is too troublesome to fill out forms. They require additional charge; charge migrants additional money for filling out insurance forms, and have just refused it outright.

Mr. HUERTA. There is some question as to the credibility of this plan in the eyes of the traditional providers of service, so it is questionable whether they are going to receive money or not, so the easy thing is to deny services.

Senator KENNEDY. As a result, what happened? As a result, there are fewer people that subscribe to the plan?

Mr. JUAREZ. No. As a result they are not able to get services from traditional providers if they want to use their insurance, and the only recourse is to go to those who accept it. We have had exceedingly good relationships with the union and health plan. We have always been reimbursed for all the work they have done for them.

Mr. HUERTA. If our center did not exist, many of these people on the Kennedy plan would not be able to receive service.

Mr. JUAREZ. The appropriateness and the use of these resources brings me to the second topic of crisis, and that is a crisis of reaction. In the crisis of reaction we, that is the migrant health centers, are continually asked to justify our existence in terms of competing in the medical care market. This is in terms of whether or not we can provide adequate health services at a reasonable cost. These seemingly reasonable questions become intolerable when they become devices for political harassment when local medical societies and dental societies insist upon investigation, either through their influence with their Congressmen or through their influence upon specific administrators within the Department of Health, Education, and Welfare.

We have been subjected to such harassment continually from the onset of our projects. We have been asked to produce cost data that requires a highly sophisticated system for which we are not funded. However, I would like to point out the following: The New England Journal of Medicine published an article on June 8, 1972, entitled "The Cost of Services at Neighborhood Health Centers." While this article has been methodologically criticized, and although it does primarily deal with urban health centers, some of its findings can be usefully applied to our projects. The article states, and I quote:

> A frequent question asked regarding provision of health care services to low-income persons is: "Why not contract with Kaiser, HIP and other existing prepayment group practices to provide these services?" These groups are nationally recognized as representing an acceptable standard of cost and quality care, measured most often in terms of premium and utilization rates. (P. 1244)

The article goes on to explain that the Office of Economic Opportunity, in fact, has experimented with these prepayment plans. The article points out that for the three basic services of medical, laboratory, and X-ray, rates range from $74 to $93 per person annually. If medicines are added, the ranges increased to $83 to $111. If other support-

ing services are added, such as home health, mental health, transportation, community organization, training, and community services, then the article states:

> Addition of other support components brings project cost level of the primary comprehensive care package for these prepaid group practices to range from $164 to $241 per person per year. The similar cost data for Neighborhood Health Centers would range from about $96 to $153 for primary clinical medical care . . . The costs of primary comprehensive medical care would range from about $134 to $233—an apparent competitive advantage for the Neighborhood Health Centers . . . (P. 1244)

The study concludes that:

> Mature Neighborhood Health Centers of reasonable size can operate complex systems efficiently. Probably the smaller centers in temporary quarters and centers struggling with start-up administrative problems could not become competitive until their population exceeds 10,000 registrants.

I would like to point out that in our small centers with temporary quarters, struggling with startup administrative costs, we have a combined 13,091 individuals, and have provided basic medical, laboratory, and X-ray services with a combined budget for fiscal year 1972 and $1,079,622. Dividing one by the other, we find that we provided these services at an annual cost per person of $82.47, which compare more than favorably with the $96 to $153 range reported for the large urban centers. It also compares with advantage, to the prepaid group rates which range from $83 to $111.

Of course, we are not mentioning that we are including the cost of equipment and facilities, which cost-accounting methods would capitalize over a 20-year period to include only one-twentieth of the total costs in 1 year's reports.

Neither are we mentioning that besides primary care, X-ray, and laboratory services, we provide home health care, social services, training, and transportation as needed. Not mentioned either is the fact that in collaboration with mental health units in the two counties, we provide at no cost to the center the services of one psychiatrist, and four psychiatric social workers as needed. Moreover, in collaboration with the University of California's School of Optometry, we have been able to provide at no cost to the center free optometric services. Glasses are provided to those patients who need them, at cost.

In addition, the migrant center at Brawley provides the services of a cardiologist, a gastroenterologist, and allergist, a neurologist, and an orthopedic surgeon on a regular schedule. These services are provided for the center's enrolled families at the sole cost of transporting these specialists from the University of California Medical Center in San Diego. These services, again, were obtained thanks to the personal and professional advocacy of the center's physicians.

As indicated above, all these services can be provided by an established prepayment plan at a cost range of $164 to $241 per person per year—excluding perhaps optometric services and some social and community services which would command even higher rates.

Let me say, gentlemen, that my cost accounting report to you today is simple. If you gave us $111 per year per person enrolled in our health centers, as it is reported that prepaid group practices are receiving from OEO to provide physicians, laboratory services, and pharmacies, then the combined budget of our Orange Cove and Brawley centers would have been about $400,000 higher than it was for fiscal 1972.

And, of course, if we included in the prepayment plan the costs of providing the social services, the transportation services, and the rather sophisticated specialty services that our projects provide, then we would have received approximately $3,154,931, or an increase of over $2 million over the combined $1,079,622 that our centers received in fiscal 1972.

Gentlemen, if you feel therefore that prepaid group plans or comprehensive urban health centers can operate at less expensive levels than our community controlled farmworker clinics, I invite you to fund us on the same basis.

I would also like to invite you to analyze the crisis of reaction in this light, by asking other local providers to demonstrate that the health care services that we render could be provided at a cheaper rate, by them or by entities which they would devise.

With regard to the crisis of politics, we are continually asked to be apolitical while those around us inundate us in political mud and practice various forms of vilification and character assassination to the best of their ability. Consumer participation is trifled with and threatens to become a mockery. People who are antipathetic to the interests or expressed desires of seasonal and farmworker members of the board, sit on the same board with them, and when the poor people vote their will, then professionals resort to such tactics as writing to their Congressman, as well as to the administrators within the Department of Health, Education, and Welfare. It is unfortunate that collectively they can bring so much political pressure to bear that it forces responses on the part of the funding agency that are harmful to the well-being of the people which the agency was set up to serve. It is an unfortunate aspect of this entire problem that there seems to be direct collusion on the part of some of the staff of the Department of Health, Education, and Welfare, to thwart the collective will of the consumer board.

Is there a process by which an administrator can thwart the intent of Congress with legal impunity? We submit to you that there must be, because recently funds in California have been frozen pending the development of a "California strategy."

Since we only work directly with the population that will be affected, no one has seen fit to apprise us as to what is entailed in the development of the strategy. This, despite the fact that the legislation says that our consumer boards should participate in the determination of what services will be rendered and how they will use resources allocated to them by the Department of Health, Education, and Welfare.

The State of California is unique, in that in this State these programs have created a tremendous political furor to which some of your colleagues in Congress have reacted with negative results for poor people. If it were not for the support of such Senators as Cranston and Tunney, and some of the members of this subcommittee, the results could have been catastrophic. As it is, we are faced at the present time with a task of attempting to explain to those migrant and seasonal workers who sit and deliberate, and do the best that they can, that they will not receive additional moneys until somebody else decides what is good for them. That is pretty traditional, but it is also pretty cynical in view of the expectations that are engendered when we speak about the participation of consumers in determining their own programs.

84 852 O 72— 5

We assume that the reason for so much indignation on the part of the established medical care providers is the fact that some poor uneducated farmworker has the temerity to step forward and attempt to claim what should rightfully be his, which is a decent health care standard, regardless of his ability to pay for it. I assume that their attitude, and that of some insensitive administrators must be, "how can these people be so bold as to demand that they be taken care of as human beings?" It is about time that these providers and these administrators understand that their political life is not more important than the life of a poor farmworker, and that their paternalistic attitude is not only undesirable but much resented by those who have been continually subjected to it. Since the people that we deal with do not have large lobbying activities or sums of money to pour into political coffers, few if any of their complaints are listened to with the same intent and devout respect as those of more fortunate members of specific political constituencies.

This will probably be one of the few opportunities that we will have to bring these facts to light and perhaps by saying them to this committee, you gentlemen, who are elected as representatives of all of the people of the United States, might insure that your legislative will is done and that people commence responding more to the real needs of human beings and less to political pressures.

This is of tremendous importance at the local level where our problems are not philosophical but practical and very real. Recently a young man walked into our clinic. He complained of chest pain and shortness of breath. He was evaluated by one of our physicians who diagnosed a heart condition which if not corrected would lead to an early death. Because this man was a recently arrived alien, he was not enrolled in any program which would provide for his health care. Fortunately he came to our center where our physicians and other staff advocating on his behalf succeeded in having him admitted to the University of California Center at San Francisco. There, he underwent heart surgery within 5 days. Recently he came to the center for a followup examination and he thanked those who had assisted him. Without the specific advocacy of the center, he might well have died at an early age. His only fault being that he, like thousands of others, does not fit into any of our neat programmatic medical insurance plans; nor does he have the resources to provide for his own care. He works in a most difficult and strenuous occupation, that of picking the food for your tables. The fruits of his labor are like those of many like him; he is poor, alienated and excluded from most meaningful social legislation; for although we are willing to benefit from his misery we are not willing to accept, and readily extricate ourselves from, the responsibility of providing for his most basic needs. This may be politically, and economically expeditious; but it also appears cynical and immoral.

If we have done something to facilitate the deliberations of the subcommittee and help augment services to the migrant and seasonal farmworker, we are most happy. If we have not, then we are saddened, but not despondent. For as long as there is a crisis of need, we will follow the example of the migrant and seasonal farmworker and we shall endure. We shall endure the crisis of reaction and the crisis of politics. We shall actively work and advocate until together with him, we achieve at least a minimal amount of justice in adequate standard of health care.

Senator STEVENSON. You have been very helpful, Mr. Juarez, and the subcommittees are grateful. I think we will proceed to the other members of the panel, and then we can address questions to the entire panel.

The next witness is Mr. Johnny Johnston, a board member of West Palm Beach migrant health project, sponsored by the West Palm Beach Health Department.

Mr. JOHNSTON. Senator Stevenson, I have a prepared statement, and if the committee will bear with me, I would rather not read it. It is rather short, and I have brought sufficient copies of it. But I would like to just make a few observations——

Senator STEVENSON. We will enter your statement into the record, Mr. Johnston, at the end of your testimony.

Mr. JOHNSTON. In my prepared statement I endeavor to speak on three subjects: availability, quality, and continuity of care.

In listening to the various reports so far this morning, I think that the three were well selected. We can see here that the migrant problem is one that everybody has well defined as being one that has a great need and one that poses difficulty in being able to solve that problem. I would just like to say that in view of the opinions rendered and the facts stated and the many figures given to justify the different trends of thought, that in my mind there is just one thing that we really need to come to a conclusion on, in that we have already decided among ourselves that there is a problem, and that the problem needs to be solved.

Then we need to put in our mind that we want to solve the problem. It seems that everyone can say that it is a difficult problem, but no one is willing to come out and say they are unwilling to tackle the problem, difficult though it may be. When we talk about availability of care, we think about services, moneys and personnel.

It is rather intriguing to me that we can get money readily to make studies about migrants when we cannot get money to meet the needs of the migrants. When we talk about continuity of care; it is intriguing to me that we can continually fund the local State health departments and county health departments to meet the needs which they admit that they cannot meet, when we cannot get the money to get the programs that have demonstrated that they are willing and can to some degree meet the needs of the health needs of migrants.

Continuity to me is being able to be aware of what needs to be done to solve the health needs, health care problems of the migrants. I would just like to say to this committee that if you do anything to improve the health care of migrants, that is to establish a way to insure the continuity of care, to involve the migrants themselves in the health care delivery of migrants, to involve genuine concern, where in more than a political expediency was the necessary thing. When we think about migrant care, most of the migrant money is sent to State or county operated agencies. These agencies are hindered in a great degree by State regulations wherein the consumer-based operations to some degree can follow the Federal regulation more freely and in my mind can better give a continuity of care, can better give a quality of care wherein they can carry out the intent as set forth in the HEW guide. I thank you.

Senator STEVENSON. Thank you, Mr. Johnston.

(The prepared statement of Mr. Johnston follows:)

PREPARED STATEMENT OF MR. JOHNNIE JOHNSON, CHAIRMAN OF THE CONSUMER POLICY BOARD FOR THE PALM BEACH COUNTY HEALTH DEPARTMENT MIGRANT HEALTH PROJECT.

GENTLEMEN:

I have been associated with the Palm Beach County Health Department's Migrant Health Project since April 9, 1970, when I was elected as Chairman of the newly formed Consumer Policy Board. Since that time I have been selected for membership on the National Migrant Health Advisory Committee for the Department of Health Education and Welfare and on the Consumer Policy Board for the East Coast Migrant Project. I am an ex-migrant agricultural worker presently employed by the Post Office at Belle Glade, Florida.

In speaking of health care for migrants, three points need emphasis:

Availability
Quality
Continuity

With regard to availability, the Palm Beach County Health Department has done an excellent job with the limited amount of money designated for the program; however, more personnel are needed and some means to provide for payment of hospitalization before a person develops into an emergency case. In order to provide truly comprehensive care to the migrant population, more facilities are needed, but above everything else we should have better coordination at the National and State levels of the money and effort being devoted to migrant health. Programs are being funded through H.E.W., O.E.O., the Department of Commerce and through the Office of Education. Each seems to approach the problem as if they were the only ones in the business. The most good could be done by expanding and improving the programs that have been operating in the health field for a long time.

With regard to quality, I feel that improvements in facilities and in numbers of professional people should result in better quality but they should be people who are committed to full-time duty in providing health care for the migrants. When we speak of migrants, we're talking about a population that requires a lot of understanding. They have many needs in addition to health, such as education, and social handicaps. They need to be taught how to take care of themselves.

If availability and quality are improved, then continuity will improve, but great improvement can be brought

about by provision of some kind of health insurance that will cover the cost of care when the migrant is out of the area where health projects operate.

In testimony I prepared for the President's Committee on Health Education, I said that the migrant is the most displaced and undefined person there is. He is labeled as a migrant, a seasonal farm worker, a non-migrant and a general nobody. I label him as a person who truly needs help.

Senator STEVENSON. The next witness on this panel is Olga Villa, who has worked with migrants in Florida and Texas, and I understand also in Ohio, Michigan, Illinois, and Wisconsin.

Ms. Villa, do you have a statement? Do you want to read it, or summarize it?

Ms. VILLA. I would like to express some thoughts off the top of my head before I go into the prepared statement. With the growing level of consciousness and identity of farm workers themselves across the country, we will see many reactions, many reactionary measures taken in funding the programs, and I am talking about consumer programs. I am specifically talking about consumers in boards that are so desperately and critically needed to go along with the migrant health programs. If we are talking about self determination and not making them empty words, keep this in mind as I am reading this statement, and also my statement is going to take you into another area of the country. Many people have read about it. Many people have spoken about it. Many people have visited this part of the country, the Midwest.

Yet today I can quote studies, data, other material related, but again the faces of migrant field labor is changing in the mid-West, but it cannot do without migrant health programs, because we are faced with a special type of problem for the farm worker, that of having a heavily concentrated amount of farm workers for a small amount of time creating almost a crisis situation each summer. So our migrant health programs are not the Lone Rangers. They are part of a definite strategy, and part of, we hope, a national program that will be developed to help not only farmworkers but resettling rural and poor people.

Migrant work streams remain relatively the same today, but with different faces in the mid-West. The open-air fields are changing to heavy duty equipment, like cherry harvesters, beet machines, and tomato pickers. The next echelon of work is in the canning factories with people working 12 to 14 hours a day, with little or no extra provisions being made for children or benefits that would accompany a factory worker, who is a stable citizen of a community.

Many programs are being instituted to alleviate these conditions. Programs such as migrant resettlement projects like in the State of Indiana, with the Department of Labor national farmworkers program retraining migrant workers in vocational training to those who wish to resettle in an upstream area. These types of programs are working in Michigan, Ohio, and Wisconsin. Migrant families are staying in small, rural communities to become stable citizens. Yet we are only talking about a small percentage of persons who have any type of services available to them. We are now talking about areas like the southeastern corner of Michigan, where 40,000 to 60,000 migrant farmworkers congregate each summer to do field work and this season the clinic established there has already reached the point of serving the number of migrants they helped all during the season last year. There is a myth that each year less and less migrants are needed for field work, it is just that—a myth.

If we are talking about realities we are saying that more migrant health moneys are needed to serve migrants who travel a couple of thousand miles to do the Midwest American a favor, that of working in the fields, harvesting and canning of the luxury food items that are consumed across the country.

Migrant health clinics in the Midwest have provided opportunities for many migrants not only to be consumers of the programs but an opportunity to find employment through the clinic itself, and open a whole new area of work to migrants who would like to go into some type of employment.

Continuity, quality, and methods of delivery are a priority for migrants health clinic in the Midwest. Continuity in handling referrals that are sent with migrants from their home base, in the type of care, or in referring patients to clinics in home base States; quality in mobilizing the best available resources and people to staff clinics. Methods of delivery have changed from the back of a car trunk to experimental programs dealing with the HMO concept, and how this type of program can work with migrants.

It would be a serious oversight to assume that the numerous agencies and programs throughout the upstream areas are classified as migrant health projects to the specific field of migrant health. Many of the health projects are multifacet programs which provide comprehensive service to the migrant, the "settling out" migrant and the "settled out" migrant; services which, if discontinued, would result in a shortage of desperately needed migrants clinics and health services.

One example, of which there are many, is the Muscatine migrant health project in Muscatine, Iowa (located on the Mississippi), focusing its services in an area which employs several thousand migrants in agricultural work and food processing plants; this strategically located center serves migrants and settled-out families in both Iowa and Illinois. In the past several years it has grown in scope and in personnel to meet the increasing needs of farmworkers and their families in health, in adult basic education, in bilingual programs for migrant and settled-out children, in consumer education, family stabilization, and job development.

As a leading example of the critical need and potential of upstream migrant health centers, the Muscatine project serves as a basis of operation for not only its year around professional employees—directors, nurses, nurses aides, and other outreach medical staff, but also for VISTA volunteers, Planned Parenthood workers, educational program developers, food stamp services, and legal assistance. The migrant center coordinates and directs weekly clinics staffed by competent medical personnel from the University of Iowa, and Muscatine Center provides thorough and comprehensive services, X-ray, dental physical examinations, hospitalization, prenatal care, et cetera, throughout the summer months during which the migrants stop to work, settle out, or pass on to other areas.

Similar to other health centers scattered throughout the migrant stream, the center houses a thrift shop which provides migrants with a wide selection of donated articles, clothes, furniture, refrigerators, stoves, and classrooms for migrant youngsters, expectant mothers, and family heads seeking employment. In short, this "health project" is the center around which a considerable number of services all necessary for the general welfare of the farmworkers and their families revolve and sustain themselves. The elimination of such projects would have serious social, political, and economic repercussions in the immediate area of the operation itself and throughout the migrant stream.

As we move into talking about another reason why migrant health funds are critical, we start talking about discriminatory nonprovision of medical services by—

Hospitals who do not abide by Hill-Burton Act, and when they do only for the settled urban poor. Sometimes not even for those.

Welfare departments which deny medical care benefits to migrants on pretexts such as nonresidency, inability to foresee number of recipients and thus inability to appropriate moneys.

Doctors who refuse outright to provide services to migrants on pretexts such as too many patients or language barriers or outright racial prejudice.

By health clinics in existence to aid local citizens—on the same excuses as above.

By all of the above failing to provide for the language and cultural differences of migrant workers—thus creating an unbridgeable gap between the migrant and health care.

Thus, what is needed is a bridge over troubled waters in the form of money from the Congress of the United States. With all the best intentions in the worker, the persons who work with the clinics cannot work on hope; there must be more money for migrant health programs in the Midwest. Health services must become a service available to all, not a luxury for a few.

I firmly believe as you go across the members of this table, some of us have reached a level of frustration in dealing daily with migrants in medical health services, but I feel this frustration level has pointed us to a level of action, and we sincerely hope that this subcommittee will listen to us, make specific recommendations, because we are not going home at Christmas. We are in our respective areas to stay. We are citizens of this country. We do not have barriers to cross. I believe the existing agencies should be made responsible. We do not want to build parallel agencies to serve a specific designed group of people. We want to become part of that establishment.

Senator STEVENSON. Thank you, Ms. Villa. Could you tell us more about the Muscatine center. What happens after the harvest season? Does it continue serving migrants that have settled out of the stream, or does the center close down after the season?

If so, what happens to its resources?

Ms. VILLA. You must understand, when I am talking about changing faces of the stream, there is continual process of seasonal farmworkers all year long.

As the season starts out, the person will come into the Midwest, maybe to plant, to seed, to work the grounds. That person might move on, that farmworker, and we get another type of farmworker who comes in to harvest that crop.

That person might move on. Then when we get another type of farmworker who comes into the processing plants, and these processing plants are growing to a larger and larger degree, and we are getting people who stay for anyplace from 4 to 8 months of the year. They are still migrant workers who travel.

So the clinic and the need for such services is continuous all year along.

Senator STEVENSON. The clinics' services do continue throughout the year; even in the winter?

Ms. VILLA. Yes. All services mentioned continually go on year-round.

Senator STEVENSON. Will the number of persons who fall into that migratory category decrease in the winter months?

Ms. VILLA. If we use that rationale, then the few that are left need more medical services because we are not accustomed to the winter.

No; they do not fall off, Senator Stevenson. If you are acquainted with the——

Senator STEVENSON. I am quite familiar with the Muscatine area. It is of course right across from Illinois.

Ms. VILLA. As you know, people in the Quad-City area constitute a large percentage of Spanish-speaking people. There is a large resettlement project in that area, sponsored by several agencies.

This area every year—and I have data to back this up—settles over 150 families. That is a lot of people staying; and migrants do not become exmigrants or settled people overnight.

Senator STEVENSON. You suggest that they are staying, and that you continue to serve them, and at some point I suppose they drop out of the stream? At the point that they are no longer migrants, is the migrant health program still available to meet their needs, or should they not be dependent on other forms of Federal help?

Ms. VILLA. There are other forms of Federal help. The migrant programs continue to help those people who are settling out or migrants with intent of settling out.

If you are acquainted with the Illinois Migrant Council, they are in different phases of settling out processes and we can name any number of resources that are helping the migrant in the total phase of settling out.

Senator STEVENSON. This is a question that has worried me. I have been to a clinic, for example, in the Rio Grande Valley in Texas and talked with nurses who have said to me, "Put yourself in our shoes; what do we do when a woman comes to the door 9 months pregnant, in labor, and she is not a migrant?"

Ms. VILLA. That is a justification that has to be reached when that person walks into the door of that clinic.

Senator STEVENSON. I think I know what they do.

Ms. VILLA. Yes; I am sure they do.

Once again, I will emphasize that the clinic serves much, much more than just a medical clinic, as you heard me state—say in a statement.

The clinic services it as a focus, as identity for that community.

Mr. JUAREZ. Senator Stevenson, if I may, I would like to attempt a partial answer at least to the question that you asked.

My concern and the concern of some of my colleagues, not only was as a migrant, but as seasonal farmworker, and we address ourselves to the issue of seasonal farmworker, and then we get to talk about not John Steinbeck's "Caravan" across-the-country-type migrant; but we are talking about people who are moving, have high degree of mobility, within relatively limited area, 30 to 40 miles. They are seasonals. They are no longer part of the migrant stream that we were taught to look at, sort of prejudicially; there is no caravan that stops at night, where guys play the guitar and jug a little bit of wine that Steinbeck used to write about. This is absolutely a different kind of problem.

We are dealing with the issues of the seasonal farmworker and the

migrant. I think it is also of grave importance that we recognize that whether we like it or not we are being forced into the role of dealing with some of the problems of the rural, poor or near poor.

It is, you know, difficult, and certainly I will not be a party to giving answers to poor people again until we seek from everybody else simply because, for the last 2 years they happen to have lived in the same city; and I am not about to start giving them the same answer that was given to them by tradition. I think they are deserving of service, and we use them to the greatest extent possible.

In the administration's testimony this morning, I would like to address myself to some things they said.

I became very, very angry about the California freeze. In the California strategy, funds are frozen for migrant workers of California, and I do not know whether you were here at the time this issue was discussed; however, they are frozen; and the implication was that all funds were frozen in California pending the development of overall strategy. That is nonsense. All the migrant funds are frozen, all the migrant funds are frozen; not all health programs are frozen.

We saw in King City two programs that are not frozen. It tends to leave the impression that the only one that has to be frozen or studied is migrant or seasonal farmworkers. The other one, you do not have to go through that process, probably because they have to be located in areas that would raise a lot of hell.

We are dealing with transient population.

This hearing has heard testimony before on the powerlessness of such a population. It is an unfortunate aspect of trying to deal with this population that you do not generate the political muscle that you need to have, to stop people from making this kind of arbitrary decision. It is unfair to say that there is programmatic overlap. I do not believe there is programmatic overlap.

There is the center that functions, providing care right now, confidential health care center, providing the full range of services within 600 miles—I do not know where the programmatic overlap is occurring, unless they are funding programs to Los Angeles or some place like that. I have no idea what programmatic overlap is. I do know that there has been a systematic defunding of some county projects, because they have remarkably good statistics, like they see a patient every 2.4 minutes, 80 patients in 3 hours, or something like that, some ridiculous amount. That is not care. That is not medical care. That is mockery. That is shameful.

I am aware we have one of those farces going on not too far from where we are. I do consider that very much of a program. The nearest center fully operational is the one in Brawley, and that is 600 miles south of where I am. There is one that is supposed to be in between us, but the political situation is such that it has never become operational.

The next one is all the way in the State of Washington.

Senator STEVENSON. The next one is where?

Mr. JUAREZ. The next migrant health care center, next comprehensive health care center, or seasonal health care center is Toppenish, Wash., unless you go off the valley and go up into places like Alviso, and they have their population to take care of.

I guess the reason that you freeze migrant programs while you study health-care needs and do not freeze the rest of them is because mi-

grants do not have political power that everybody else has, and also the seasonal farmworkers. You have got some rather unique problems in what happened.

Mr. Huerta can tell you about what happens when they cannot pay.

I would like to tell you a little bit about what happens when seasonals cannot pay for services.

Senator STEVENSON. I think it has been stated that about 63 percent of the patients have no way to pay for hospital care.

What do you do then? What do you do if an individual needs hospital care and he falls within the 63 percent?

Mr. HUERTA. In Imperial County, we try to utilize local county hospitals. But there have been periods where the county hospital has not been able to secure the services of a physician and therefore, we have to resort to traveling some 130 or 140 miles to San Diego and appeal to the mercy of the medical center there to hospitalize our patients, or if by some chance we are able to convince——

Senator STEVENSON. You said "medical center." What is the medical center?

Mr. HUERTA. The University of California, San Diego, medical center.

If we are fortunate enough to convince one of the local hospitals that indeed this patient may be able to cover the cost of his hospitalization, and if he has sufficient property or collateral, then we may be able to hospitalize that patient there.

Senator KENNEDY. At the medical center?

Mr. HUERTA. At the local level.

Senator STEVENSON. Is there a problem of admission at the medical center?

Mr. HUERTA. Most of the patients that we are able to hospitalize at the medical center are those cases which the hospital considers teaching cases and are of an unusual nature. Otherwise, they will not accept them either. And also because of our close proximity to the border, the patient will go to Mexico and seek services there.

Senator STEVENSON. Do you mean American citizens crossing to Mexico?

Mr. HUERTA. Yes, sir. Imperial County is unique, because as I mentioned, it is only 20 miles from the Mexican border, or the county borders with Mexico, and the entire Imperial County has a population of 75,000 persons, and the city on the Mexican side is a city of 400,000 individuals, and there are approximately 600 licensed physicians in that area, and most of their patients come from the American side of the border.

Senator STEVENSON. These are American citizens, not illegal aliens, who cross the border to Mexico to seek health services that they cannot, because of poverty, receive in the United States?

Mr. HUERTA. Not only do they cross, but they also reside in Mexico, because they are farmworkers and the wages are minimal, and it is much cheaper for them to live on the Mexican side of the border.

As an example, the average rent for an apartment is 300 pesos, or $24 American money; so it is much cheaper for them to live on the Mexican side.

Now, when they come into the United States for medical care, they are denied medical care because they are not residents of the county;

they are not residents of the United States, even though they are American citizens.

Senator STEVENSON. The services they receive in Mexico are from doctors in private practice at lower cost than in the United States; or are these publicly provided services?

Mr. HUERTA. These are all private, fee for services, services that they receive. If I can give you an example, the average physician visited in Imperial County is approximately $8 and in Mexico it would be $3. It is much more economically feasible for migrants to cross into Mexico for their care, when they cannot find care elsewhere or cannot afford it.

Senator STEVENSON. How does the quality of care compare?

Mr. HUERTA. It has wide range, but I would assure you the migrant receives probably minimal or low-quality care simply because, in Mexico, there are not the laws pertaining—laws pertaining to medical service is not as stringent as the United States. Therefore, they have a large number of people who practice medicine without a license or under any form of regulation.

Senator STEVENSON. I address these questions to the whole panel.

Would you be in favor of a separate congressional authorization for hospital care so that in your request for a continuing grant, you would be able to request specified sums of money for that purpose?

Mr. HUERTA. I certainly would.

Mr. FEDAN. We certainly would be in favor of a separate funding pattern for the hospitalization. Really, I am at a loss as to where to begin even to say why we would need it, because I really think that most of the reasons have been covered in various testimonies. I would like to add simply that in our center, Orange Cove, and I think Brawley center had similar experiences, that at least 60 percent of the people are not covered by any form of insurance, that hospitalization being a rather sophisticated form of insurance coverage, you know it is even higher; that is, people that are covered by some form of insurance but are not covered by hospitalization.

Senator STEVENSON. Mr. Johnston, you made some observations about State regulations.

Could you elaborate?

Mr. JOHNSTON. I am from Florida, and most of the migrant and health programs are run by State and county health organizations, and these organizations are usually governed by State regulations concerning personnel, and so forth.

Senator STEVENSON. Is your opinion based on experience in a particular State? If so, which one?

Mr. JOHNSTON. In Florida.

Senator STEVENSON. Florida?

Mr. JOHNSTON. I am more familiar with the black migrant, even though he is not as large a part of the migrant population as the Mexican American, but there is a substantial number of black migrants and the problem with black migrants to some degree I am more familiar with that than Mexican Americans.

In the black migrant population you have more seasonal farmworkers than you do really the migrating migrant. When I think of health care for migrants, I have to think along this line. To me the best thing that has helped them for migrants, as I know there are such

things as HMO's and comprehensive health care for migrants, and in most State-run programs we find most of the care on the episodic side of nature—there is nothing being done on a comprehensive basis, because we are having a problem to make the changes, to conform to the regulations, you have to go through the State legislation and get certain laws or statutes changed, wherein you could conform to them.

These are the problems that I see.

We had a project that came out that we should have a consumer policy board; in most States they could not conform to the regulation, if they come in conflict with State rules and regulations concerned with personnel. With our specific project in Palm Beach County—I am chairman of that board—and what we did to keep some form of migrant health care going on was to sign a resolution delegating authority that had been given to the consumers back to the States, so the States could adhere to State regulations. So you could see the problem that we have there.

When we talk about hospital funds, I certainly would suggest that hospital funds be set aside, you know, separate from existing funds, and that maybe through this committee or by some means the funds could be delegated in a manner wherein the services would not be handled by State regulations and that the major programs that are funded by HEW are State run.

Senator STEVENSON. Do State and local regulations commonly require a degree of consumer participation?

Mr. JOHNSTON. The degree of consumer participation increased about 2 years ago.

Senator STEVENSON. As a result of what?

Mr. JOHNSTON. As far as I know it increased as a result of policy from HEW concerning——

Senator STEVENSON. What about State and local regulations?

Mr. JUAREZ. State regulations, it has been our example, generally address themselves to administrative processes and not to citizen participation. Therefore, it is highly unlikely that you are going to have any kind of consumer participation in any kind of health care services provided to State agencies.

In fact, some States were threatened with a loss of their funds unless they created and were given 1 year for compliance, unless they created consumer advisory boards. Ours is more than consumer advisory boards.

Senator STEVENSON. You are getting at my next point, which is how the HEW regulations on consumer participation are being implemented in the States and at the local level. It would be helpful to us if you could address some comments to that question.

Mr. JUAREZ. We have an advisory board comprised principally of professionals in various fields. Then we have administrative boards which is a policymaking board, which is comprised mostly of migrant and seasonal farmworkers. Some of our board members meet the definition of migrant in the most classic sense, in that they leave the State of California and miss two or three board meetings when they are out harvesting in Washington.

The way in which the regulations affect us is in a very positive vein, because for the first time, people have alternatives—they have created

alternatives for themselves, in the education process—that is, if they were not hampered so much by a lot of politics, of which they have no control, but actually were able to exercise programmatic controls, they were supposed to, then I think the quality of service would go up.

Because they are more apt to demand more of what they need than administrators are willing to give them, if they do not advocate for themselves.

Under the consumer advisory board or on the consumer advisory board that we have, they do just exactly that. They advocate for themselves, and they decide priorities on what they want the money to go to.

It was our recent experience that we had a proposal from one of our dental societies offering to provide, on fee-for-service basis, service to the clinic, and the consumer board rejected this. They could see no way of developing any ongoing or continuous medical care by attempting to refer out what medical and medical care were not covered. They did not see that as a viable role for themselves. That is quite a step taken, development of sophistication, to understand if you are constantly paying out and developing no capital, no process for service delivery, that you are developing nothing but additional payments systems.

Senator STEVENSON. Is there not also a medical question as to what kind of health services are needed and can, within the available resources, be delivered?

Mr. JUAREZ. Say that again.

Senator STEVENSON. I am asking if it is not also a medical question involved in determining your priorities, as to what services are needed in the area and what can be effectively delivered with the resources that are available?

Mr. JUAREZ. I think that is a medical question only after you have had a sufficient amount of experience to attempt to deal with the priorities settled by the people first.

If no one has prior experience, a physician can only come in and make judgments as to what medical priorities should be once he has had experience with the population.

Then he has recourse, if he is employed with our center, of thus making recommendations to the board and thus setting medical priorities.

I do not believe that you can, aside from describing generalized health needs as has been done by Federal regulation, you cannot specify, you know, in each separate case what is necessary for each independent project, because the needs are different.

Mr. FEDAN. In this particular case, the question was never a medical question. It was a question of organization. The decision that the board made was one which involved how is the money going to be channeled.

The decision they made was whether or not that money was to be used to pay outlying area dentists for the care they would provide to out patients versus having our own dentists onsite.

The board felt and voted so that channeling this money to pay to the dentist in the area would be no different than from—essentially being the same as medical or any other party payor. They strongly felt that their role was not to obtain third-party payments for private physicians.

Ms. VILLA. Addressing myself back to the question of consumer boards, there is going to be a very slight change in the Midwest, because in the new regulations of the migrant health provisions, they specifically state that in grant-giving mechanisms a policy or advisory board be created. Once again, I remind you of a particular aspect of the Midwest: we have a large number of migrants in a small amount of time; and this is going to be difficult, but it is not that difficult to obtain.

I would certainly hope, and as we are going through now the creation of advisory boards, that these regulations and guidelines that are written up have some strength and have some teeth by the administration to go through implementing these boards to the projects.

We have a dual system of county boards, not specifically in the Midwest but, like Johnny was saying in Florida, the money goes to the region, and the region goes to the States, and the States usually allocate them through local health departments, and there are laws enacted by the State legislators that prevent these moneys from being handled by policy or an advisory board; and in this instance, it would be migrants.

We are watching very, very closely the development of these boards and these advisory committees, because they must come about if the consumer is truly to become a recipient, not only of the services but of the actual involvement in the projects.

Mr. JOHNSTON. I would just like to say concerning consumer boards, this is a problem we have. In some places, you might have what you call policy boards. In other places, they are advisory boards.

I think when the regulation was brought out, they were going to be policy boards. And difficulty arises when one part of the regulation says, well, the board should not involve itself in the day-to-day operations of the project. This is stretched a long way as to what is the difference between day-to-day operation and to what the board should really be concerned about, making policies or set priorities only. And within the State-run or county-run programs, we really have advisory boards, and there is a whole lot of problems that evolve when you start talking about consumer or policy boards.

You have State planning agencies. You have the local planning agencies; and by the time you meet all the regulations set forth by these agencies, you really do not have a board really doing that much.

Our board is one of the better boards in Palm Beach County. I am chairman of that board and I can truly say that the board has at least done some good in that it has been affiliated with the Department to at least know what they are doing after they set the program in action and can relate that much to the people.

I would not say that we really have come to the point of making policy; because generally what is said that we do not have the expertise to really set policies, we do not have the know-how to really budget and make priorities where money should be spent and different things like that. It has been said that some group was being sought for contract to train the boards.

I understand this is going to happen over a 2-year period, by which time we will probably have a new set of regulations and the board will not be any good; and we start all over again. So it was a very good idea; but we still come back to the same problem. We have the need for the board, but nobody can really come up with a way to make the

board function. I do not think there really is a truly viable board in that there is no board that has finer means or methods to go around or walk within the regulations as opposed to State regulations governing the grants or the grantee.

Ms. VILLA. Just another remark.

There is no instant consumer board and member, no such animal has been created yet. I do fully believe that if migrant consumers can become board members, it is going to be a matter of time.

You asked about the medical services, if they were to take this—well, this is typical stereotyping you get from a lot of people. You say, How can you administer a shot; how can you give an operation—this is why we need money; because we can create our priorities and purchase the services of a physician.

The market itself dictates what hours the clinic should be open. If there is an epidemic or long line of flu, whatever it may be, that priority is going to come from the board.

What type of services they want is really essential to making their project go. You have heard testimony this morning from California where there is three of the largest consumer-based projects in the country; and I think we should seriously look at these projects and their development of their consumer boards and the policy role to other parts of the country also.

Senator STEVENSON. Can you tell us a little bit more about your experiences with consumer-based projects on the one hand and on the other the projects sponsored by medical societies, State and local health departments, and the like?

Ms. VILLA. I will start out with the consumers. It is a very simple thing.

You have heard testimony from the project at Orange Cove and the other project. The amount of services offered at these clinics is tremendous. It is almost more than an average citizen could obtain, and on the policy board, the people are not only serving as members, but they also have pride and dignity in their program. It is their program. They are administrating it.

Secondly, when you walk into, let us say, a county-run health department project, the stereo atmosphere, you walk in, and by chance if they have an interpreter you are in luck. If they do not, you sit there and wait with a number in your hand to be called.

Third, such as in the case of Johnny in Florida, you travel long distances, maybe from one part of the State to the other and face all types of discriminating practices at hospitals, private physicians. So basically the only difference in consumer-run projects and the other kind of projects with migrant health moneys, the people's support and interest generates much better quality of service, methods of delivery. And with the underlying dignity, it is their project.

Mr. HUERTA. I had a couple of comments.

One, in our particular project we have performed an alliance with the medical center again at the university so that one of our board members represents the Department of Community Medicine who is able to offer sophisticated comments in regards to medical programs and so forth.

This person is a physician as well as a professor at the center there.

In addition, we have a board member who, up until very recently was the head of the farm workers health service with the State of California, who also has considerable experiences in programs.

But I think the real point I wish to make is that by having the consumer program, its benefits are beyond that of just the center. Our board has become sophisticated in the 2 years of operation, so they have gained a certain amount of dignity that was not there before. They have been able to work in their individual little cities, have been able to start community programs that are very—that are patterned very much like the clinic. They have established consumer-board types of city programs, and so as you see, the benefit is not just for the center, but it goes way beyond that into the community.

Senator STEVENSON. Are the consumer-based projects as a rule able to develop good relations with professional groups, hospitals, and so on?

Mr. HUERTA. In our case, unfortunately, our influence for some reason is out of the county. It is with the medical center in San Diego, simply because the local medical center time and time again has said they want to do nothing that can be construed as support for their program; so they have applied pressure on other local physicians who might otherwise have become involved with our center, although this is changing. But it is still very negative.

Senator STEVENSON. Any other comments?

Mr. JUAREZ. Our experience has been in Orange Cove generally the same. We exist in a rather hostile atmosphere, in terms of where we are at in relation to medical professionals. They do not like us as a matter of philosophy. I do not know why not. It is our understanding we are not hurting them at all. They are still seeing a great number of patients and still overworked.

There are specific providers with whom we do get along. Our physicians are on the staffs at local hospitals and take calls that any private physician would have to do. I would like to address myself also, just momentarily, to the consumer board and discuss the sort of scattered effect of what happens by having an entre into the community, the center makes itself a viable entrance point for other services to be delivered into the community.

People who are normally inaccessible because there is no communication channel, become accessible not only to us, not only to our own center, but to other medical providers serving the same population.

You speak about the fact that we have mental health service there which costs us nothing. The University of California uses us as an entrance point for their mobile clinic.

The development of cooperative systems, so that we do not all ask for funds for the same thing, is beginning to occur. So long as there is some type of personal involvement, there will be this kind of effect and it will be this kind of feeling about it. There is also educational process that goes on for the consumer participation on the board where it regards emotional and mental illness as something not to be hidden and something to be dealt with as an illness. They do not hide members of their family who are emotionally disturbed.

We have seen that happen occasionally, where we have gone into their homes and had people hiding members of their family, and intervened.

These things are happening. These things can be demonstrated and they will continue to happen as long as we have an entre to communities, as long as we are accessible.

It is our accessibility that makes it valuable. It is citizens participation and not his feeling of complete inability to cope with anything.

Mr. HUERTA. Let me give you another example of the consumer program.

Again because of our very close proximity to the border, we have a terrific problem of TB. Again, there are a large number of residents in the county who have recently immigrated into the United States, legally immigrated into the United States.

When they contact TB, we report these people to the health department, and theoretically they go to the health department and seek care.

Now, the health department, in turn, because of recent immigration, report them to the immigration department, because they have not been in the country over 5 years and therefore they become a liability to the Federal Government anyway, and they are reported to the Federal Government.

Now, once they become aware of this, they will not go to the health department for treatment simply because they do not want to be turned down, so they come to our center because they know very well that we are not part of the established delivery system there, and we will not report them to the immigration department; so we are able to practice communicable disease control simply because we are a consumer-based program.

Senator STEVENSON. Do you find attitudes among professionals changing as consumer-based projects continue and are accepted in their own communities? Does the hostility which you refer to begin to abate and do they become more accepted?

Mr. HUERTA. One of our big problems is the active opposition of some of the organized health care providers.

Senator STEVENSON. That is what I am getting at. Is that continuing, or is it beginning to change?

Mr. HUERTA. I do not perceive any great change except in individuals. The policy for most of the health care providers from the area is that they are hostile to us.

Mr. FEDAN. Just to add to that, the point, I think, is this: that when the programs started, it was a question of whether we are going to be there the next month. A year later is whether we are going to be funded for the next fiscal year.

Two years later, the critical issues are no longer whether we are going to exist or not, but what is the internal organization of the project; for example, whether or not we are going to be able to add a dental program, whether or not the migrant funds are going to be increased.

So this developmental change, I think, has occurred as a whole. Nevertheless, I think we still have countless times in which opposition has made itself quite clear.

Mr. HUERTA. Also, Senator, we have been able to obtain services from physicians who have come specifically to the centers, which is not available in the county. Therefore, other physicians want to avail themselves of these services, and I am talking in regard to orthopedic

surgeons. I am talking about board certified internists that our particular county does not have. So it is very hard to feel bad against someone that you want to form a partnership with. So sometimes by doing this, we have been able to form a bridge where previously none existed.

Senator STEVENSON. Primarily with individuals?

Mr. HUERTA. Right.

Senator STEVENSON. I understand your projects have been frequently visited by site team visitors, study groups, evaluation teams.

Have you ever seen the final copy of their reports?

Mr. HUERTA. In the last year, we received two financial audits, one complete program and financial audit, plus an additional audit and program audit by Wolf & Co. So I think in the last year alone we had five different investigations going on at different times sometimes overlapping, plus various members from the Department of Health, Education, and Welfare, who made onsite visits.

For a time, I did not know what investigation was going on.

Senator STEVENSON. You wanted to respond to that question, too?

Mr. JUAREZ. I merely wanted to say "amen."

We have seen too many investigators that I think are spending more money on investigating us than on funding us.

Senator STEVENSON. What comes from their investigations?

Have you ever seen any reports?

Mr. JUAREZ. This is exactly the point I was going to make. What we have received are a number of questions, normally the process takes place, and we receive a number of questions, we get an answer, your answers were unsatisfactory; therefore, so and so will be at your side on such and such a date, and you know so and so comes up, and we never find out what happened as a result of the investigation.

I know that Dr. Bansmer and Miss Villa here were part of a site visit team that made specific recommendations regarding the California migrant program. I know because we stole portions of that report——

Senator KENNEDY. Use another word, just "borrowed" or "copied."

Mr. JUAREZ. It is honest. The report was not made public. It was suppressed. What has been implemented is those things which seem definitely directed at suppressing the program. The only thing they have implemented is the thought there ought to be an overall strategy.

You know, I know for a fact that we were recommended for a higher funding level. We have not been funded any higher, but we are frozen until overall strategy is completed, and that seems to me a very prejudicial attitude to take.

If you are going to adopt a report, adopt a report. If you are not going to adopt it, do not adopt it. Do not adopt those things which happen to fit with political strategy that you are developing for funding base. That is what angers me so much.

Senator KENNEDY. Are there any other health programs frozen in California, other than migrant?

Mr. JUAREZ I addressed myself to that earlier. There are none, only migrants need to be frozen and studied.

Mr. HUERTA. Also by the mere fact that they have frozen the funds for our programs is that it is going to have very detrimental effects on the programs, and I am sure that perhaps the strategy is to destroy

the programs and blame this matter entirely on consumers and say—look, consumer programs do not work.

Mr. FEDAN. I guess that the general pattern that we have seen over the past couple of years is simply one in which we have received fairly often all kinds of programmatic and fiscal audits, with which we collaborate readily and then we do not see absolutely any results of any of these studies.

Only by means outside of normal channels are we able to find out what they said about us.

Ms. VILLA. Elaborating on what Senator Stevenson was asking about doctors, and I do not think we could get away with the subject without putting it down for the record, of fear, when you asked about how the professionals get along, I consider the clinic has as much on a professional basis of different systems of delivering health care now; and the fear comes in the point of professional indignation, "Somebody is doing my job."

The other point is, they always bring down is that this is what they are doing, is watered down medicine; and the third and unexpressed fear is the fear for payment, that they are going to be lessened because of the people going to the clinics.

I firmly believe that if they are talking about good, quality health care, and less of official capacity, getting down to the service of actually delivering services to the consumers, and in talking about reports, we can report ourselves to death and we will never come up with adequate methods of delivering health care. It is an everchanging one.

I may be belittling myself in saying this, but in seeing many of the programs across the country, in every different facet and every different phase, run by every Tom, Dick, and Harry, there should be a national strategy. There has to be one, and it should start at the national office, a good coordinated, healthy effort by every agency dealing with the migrant.

Health is one aspect, but it is not total priority of the migrant's life.

In dealing with these related agencies, I think political barriers will and have to be broken down here, because the national strategy is just such. The harassment that goes on and everything else will have to be cleared up here, not as we say passing the buck to other people or project directors.

Mr. FEDAN. At the risk of overburdening you with information——

Senator STEVENSON. I do not feel overburdened, except with the responsibility, of course.

Mr. FEDAN. Let me just say, addressing myself to the question of studies, we know and I know that the only way you can plan is if you have data, appropriate data with which to plan. Therefore, obviously, common sense dictates that there should be some system of data collection and cost accounting, et cetera.

We are most willing to cooperate with any agency who comes down and requests from the project, like they are supposed to, that we in fact get together some place, somehow, and formulate a system that would in fact meet the requirements that the agencies have.

In fact, that which we have been subjected to is a series of crisis-oriented inquiries that do not publish anything, but leave the project totally demoralized for a period of time.

Senator STEVENSON. Ms. Villa mentioned fear. That fear exists with the bureaucracy, and especially with respect to the new and experimental programs that something is going to go wrong and the bureaucracy will be blamed. That may be part of the difficulty here.

I think we better move on. I do want to thank you all for joining us. Your testimony has been very helpful, and very convincing.

We are pleased to have as our next witness, Dr. Gustav Bansmer, Grandview Clinic, Grandview, Wash.

He is currently chairman of the National Migrant Health Advisory Committee. He has also served on other national advisory committees, including a mental health advisory committee.

Dr. Bansmer has been a pioneer in rural health and currently directs the Grandview Clinic in Washington.

We are grateful to you, Dr. Bansmer, for joining us this morning.

STATEMENT OF GUSTAV BANSMER, M.D., YAKIMA VALLEY CLINIC, GRANDVIEW, WASH.

Dr. BANSMER. Thank you.

I do not mean to be a textual deviate, but rather than read the whole thing, I thought I would summarize what I have stated in the written statement.

I think we are all aware of how the problem got here. The migrant was just like many other people, brought in because they were cheap labor. They fulfilled the needs of migrants and farmers at the time. Now they are a problem because they did come into these areas and they have stayed. Now we recognize some of the problems that they brought in.

In a quick summary, their basic health problems were those of any poor people; the composite of dirt, poor nutrition, ignorance, and neglect by the communities that sought their labor.

The first efforts to do something about the health problems of migrants—were one-shot quick and dirty clinics where people were seen quickly, given some medication and sent on their way.

As a result, you have any number of duplications. You have omissions and you have very superficial care.

The development of more sophisticated programs were undertaken, but by this time, there was a mixture of compassion, and fear; fear that these people introduced both epidemic disease or new diseases or so-called endemic disease in their area.

The migrant does have a unique situation. He is largely undereducated. He is brown. He is alien in his own native land.

Now, as to health care delivery problems:

Although the Mexican-American migrant laborer has all the hallmarks of poverty, in addition he is not fluent in English. He is obviously easily separated from the rest of the community, and I think that where they do settle out, the first and foremost fear is that these people are going to intermarry with the next generation, and this creates a tremendous social crisis within the community.

The first barrier to the usual and customary care that anyone finds in the medical program is the dollar barrier. In summary, the migrant has not only the problems of race, poverty, language, but he lives in rural America which has a medical crisis of its own.

The presence of the migrant and his limited ability to pay for medical care represents a problem that has been handled by strategic neglect.

With the passage of the Migrant Health Act of 1962, we did develop better services which established programs through health departments and medical societies, and now to migrant health centers.

Most migrant medical centers recognize the totality of man's health and recognize it not in the narrow sense, but rather in the broad sense of that totality which included his physical, his emotional and economic well being, not merely the absence of disease.

This is the so-called HSMHA philosophy, the HSMHA policy, HSMHA strategy it goes by various names. However, as sophistication of treatment of migrants and their health problems increased, there is also an evolutionary attitude on the part of organized medicine, the power structure in the community, and all of these people who represent the force of opposition.

At first, it was one of rather strategic neglect. It matured to open and vigorous hostility.

Now, I have had an opportunity to examine some of these migrant programs, and I think we can say the inequities, the inconsistencies and injustices of the health care enterprises were most painfully portrayed.

The migrant is still a very necessary force in the agricultural area. Without them, agriculture could not go on. I think we can state that the health care programs available to migrant farmworkers and his family had the following characteristics: they were very limited in scope, they were outside the mainstream of care; they were segregated from other health sources, and they were struggling for survival in a hostile environment and they lacked financial stability.

I think we should point out only in those areas where there were federally funded, federally initiated programs; was even this limited and inadequate service available.

These were the better situations and yet I must still conclude that the overall programs are inadequate and too few in number to be effective.

You ask is the program appropriate. I think we can state without equivocation that it is appropriate, that it is necessary for a large, underserved major economic need of this country—the migrant, agricultural laborer is a vital necessity to the well being of agriculture. It is completely obvious that mechanization is reducing hand labor, but agriculture will still require large volumes of labor, large volumes of agricultural technicians and mechanics.

Until such time as this Nation develops a national system or systems of health care delivery which will permit each individual to have access to comprehensive health care or until such time as the Nation eliminates those arrangements which require separate health care delivery mechanisms for various ethnic or income groups, it is incumbent on the Government of the United States to give more attention, more support to the health care needs of the migrant farmworker.

We must still recognize that this approach to the health care of the migrant farmworker is not the last and best answer to this problem—it is a temporary answer—but a most necessary answer at this time.

We must recognize that this present approach does do a significant

good; it sheds light on very basic, unresolved defects in the health care delivery system in the Nation.

Perhaps most importantly it demonstrates that the health care system in rural, agricultural America is in crisis and demands urgent attention. We must seek new alternatives for delivering and receiving health care in rural areas and we must make high quality, financially accessible health care available to all of rural America.

Is the program appropriate?

The migrant health program is appropriate. The past funding was well justified and new funding should be established—but in increased amounts.

There are at present several outstanding programs developing in migrant health—the program suffers, however, by being a conglomerate of varied enterprises.

The lack of uniformity and extensiveness is an effort at dollar stretching. With more adequate funding, a unification of effort could be developed at all levels; it could create an evenhandedness that enhance quality, effectiveness and strength.

It would and should develop systems of prepayment so that it can transcend the viability that annual Federal funding offers to a point where it can develop economic stability and become a durable part of an effective medical care delivery system. This durability can be developed from its own worth, but it must also be adaptable for inclusion into a larger, regional or national system of health care.

The program should not limit itself to "medical care for migrants," but must accept the larger definition of health care as its goal. There is an obvious commonality to the problems of migrants throughout the United States. Ironically, much of their health care problem is equally true of rural America. With this commonality of problems, it is reasonable to assume that there should be a common answer.

The basis of that answer should have these as a criterion—

1. Be uniform to insure a uniform range of services and costs;
2. An ability to integrate the program into regional and national programs;
3. The ability to exchange skills and personnel; and
4. Provide the consumer with both geographic and social mobility.

I stress that the areas of service should be large so that we do not face the irony of migrants settling in one area only because of health and welfare benefits. This is a problem we recognize very clearly in the Northwest. However, with all this, there must be sufficient flexibility so that it can be adapted to local needs and local, unique problems.

With the development of not merely a viable system of health care for migrants but a durable one, one which can utilize not only subsidies, but other sources of income, we will in reality be approaching the answer for the pattern of health care delivery in all of rural America.

Probably the delivery of health care to the migrant agricultural worker and rural America in general will present the thorniest sectors of the problem of national health care delivery.

In rural areas we have major regional variations; we have the problems created by unstable populations, as well as noncompact populations and lack of common employers.

These are complex problems but still they must be answered and we must develop an effective approach that will have both stability and latitude for flexibility. I am also confident that we have the intellectual and technical ability to accomplish all this.

The migrant health program has fulfilled the intent of its program authors—it has addressed itself to the problems of migrant health; it has made significant progress despite inadequate funding. The Migrant Health Act should be extended; it should have significant increase in funding and its scope and range of services should be extended.

Now, I have a critique of the problems of establishing health care facilities in rural areas.

One can draw best from personal experience.

First of all, any innovative effort in medicine is looked upon with suspicion, every change from the customary is a threat.

My own career began with Group Health Cooperatives in Seattle. We had a handful of families, many of whom had mortgaged their homes and farms to develop the clinic. Their intent was to seek an answer to one aspect of the economic problems of medicine.

This was promptly attacked by organized medicine. Prepaid care by any agency other than the service bureau created by and for the society was declared unethical. Therefore, any physician employed by Group Health was unethical and in violation of standards.

This meant expulsion from organized medicine.

After much painful and oftentimes ridiculous discussions we took our case to the courts and ultimately won a unanimous judgment in the State supreme court.

This was a long and unnecessary struggle, but in the process, mainly by court sanctioned opportunity to review society records, we discovered that the medical school at the University of Washington was opposed also because it represented an economic threat; the Mason Clinic was intimidated into compliance because it represented an economic threat.

Our experience was not unique. Dr. Russell Lee, the respected director of the Palo Alto Clinic, tried to console us during those years by pointing out that he learned a long time ago that the old piety of medicine—it's the principle, not the money—really means—it's the money, and the principle doesn't have a damned thing to do with it.

In rural areas, this same fear of innovation exists. It exists among the profession and the consuming public. The rural areas acquire the trappings of modernity more slowly—they recognize their deficiencies and their needs but there is no uniform voice, there is no real spokesman for rural people.

There is much saccharinity in the speeches about the good old countryside and the end result of this is that rural America suffers acutely from neglect and exploitation. This is true in all spheres of social, economic and political effort. This will continue and remain a difficult problem because of the diffusion of the population, the tendency of county commissioners to serve the power structure.

The power structure in our area is the same as we have found in our exploration of other areas—there is broad interlinkage between the press, the political structure, the commercial forces. There is gross tax inequity just as there is gross service inequity.

Just as slum areas in the inner cities have poor streets, poor sewage disposal mechanisms, inadequate social services, these are equally true in rural areas in general, and this is why rural America looks to the Federal support for innovative programs and support for those programs.

The neglect of local problems in the rural areas is probably the most troublesome factor in city problems. The municipal poor are refugees from rural poverty. Probably no area of poverty is more resistant to solution than rural poverty. Welfare programs—both the general support programs and the medical care programs—title XIX funds—are considered by the power structure as a blight, when actually it is an agricultural subsidy. It is de facto the accidental guaranteed annual wage that maintains the labor pool that makes possible the growing and harvesting of crops.

This is the background that makes the development of innovative nontraditional forms of medical care payment difficult to establish. In those areas where good use is made of title XIX funds—a reasonably, good and workable system can be developed.

If additionally good migrant health centers are created, then we create the irony that the near poor, the noncategorical people are excluded and they in their turn become the underserved.

Additionally, where migrant centers or any other health center is developed which serves ethnic or categorical groups, they do solve a technical medical problem, but add a new form of segregation and increasing estrangement.

We have tried consistently to approach the resolution of this problem. We feel that the two principal barriers to developing an effective system of medical care delivery are the almost universal fee for service methods of payment and the solo practitioner.

We do not assume that they will or should be wiped out, but groups are a better answer. George are in the minority and they are suspect because it is feared they have the potential for expansion and swallowing all of medical practice, a sheer impossibility, but never the less felt; and it represents a hazard to the effectiveness of a group.

The first approach must be educational. We have done long years of missionary work and gradually, very, very gradually some acceptance of the group philosophy is building.

Together with this there is the need to develop the climate for considering something other than the ancient, traditional method. This, too, is developing.

The outlook is brighter and the opportunity for constructive change exists. However, despite the better climate, the next hazard is funding—there are no funds other than those which can be generated from the practice. Frankly, we have found no State, Federal, or private agency willing to explore these possibilities.

In the summary I have attached a chronological review of what we have failed to accomplish despite having hired a pleasant, knowledgeable and committed young CPA to devote full time to attempting to develop support and seek seed money.

Although the HMO is a nice term, we feel it is something to talk about but not utilize. The definitions of an urban HMO are vague; but no real definition of rural HMO exists.

Suffice it to say that we feel that rural HMO's can be developed and they can be made cost effective.

A summary and review of two rural HMO type organizations was done by Richard T. Burke of the American Rehabilitation Foundation. These all demonstrate inadequate capitalization, too small an enrolled group, and as a result none of the security of adequate volume spread to dilute risks.

Nevertheless, there is evidence of workability in these programs, and the errors of the past need not be repeated.

We fully recognize the need for a rural HMO, but feel that it will be difficult to establish. If it is established, I feel strongly it should be a satellite of a galaxial system—the center of the galaxy should be either a medical school or large clinic with prepayment programs.

The most promising approach has been one that we are presently engaged in. This in effect is a rural health education center. The project's name—WAMI—Washington, Alaska, Montana, Idaho. We are teaching clinical medicine at the third- and fourth-year level. We have our faculty appointments.

In addition, we are the only community center teaching the Medex course concommitantly. It has thus far been a good wedding of two programs. We would like to engraft on this a prepayment, comprehensive care program.

In addition, we would like to develop a functional and complementary relationship to an area migrant health center which exists nearby.

Additionally, our institution houses an LPN course and this fall, we will add resident physicians. All of this is sponsored by the University of Washington through grant funds—originally Commonwealth—now DHEW.

By the use of the WAMI program which is fairly close to the definition of an area health education center, we find there is less rejection and hostility from organized medicine; there is less snide reporting by the press and we are very pleased to see the enthusiastic reception by the community and the acceptance by the students and faculty.

I do think it is important we have a prepayment program; and I think it should be on a capitation basis. As you look through these things, whether it is Texas, Illinois, New York, that is turning down its welfare programs by reporting large-scale frauds and misuse of title XIX funds, you expose the evils of a fee-for-service program and you have the old cottage system of labor. You have all the evils of piecework production. Until we go to contract programs, this evil is not going to be relieved.

I think group health in Seattle has demonstrated what you can do with capitation. They take care of aid to dependent children families at $44 a month, a comprehensive care program, hospitalization, the whole works; immunization, mental health, the whole gamut of comprehensive care.

That same program on a much more limited amount costs the State of Washington at least $66 a month per family, instead of $44 plus administrative cost of operating that program.

I do not think you can duplicate those figures everywhere else, because this is a large organization skilled in handling these things. But

I think it certainly demonstrates that by capitation you can do more with the same number of dollars.

Senator KENNEDY. It does not have dental care; does it?

Dr. BANSMER. They have a separate program for dental care.

Senator KENNEDY. Not included in the $44?

Dr. BANSMER. No; not as I understand.

Senator KENNEDY. It is a superb program. I was thinking in my own mind the figures I always hear from the administration about how health security is going to cost so much; but you can find out you can do it in a very reasonable, carefully organized structure. I think these are the best examples of it.

Let me ask you this: you have been involved in a number of studies, I understand the California study.

What comment would you make in comparison between the various migrant workers that are run, one, by medical societies, two, by consumer groups, and third, by health agencies? Which have you found to be the most successful?

Dr. BANSMER. Well, the ones in my judgment that are the most successful are the ones run by consumer agencies. The medical agencies I think you could summarize for the most part as tokenism. There is something done, and some of them have said it is better than nothing. Some of them we saw where they ran 80 patients through in a very short period of time. It is noncontinuous care; there is no follow-up, poor recordkeeping.

Senator KENNEDY. What could you tell us about the funding? You have been involved in this.

Are we asking for an unreasonable authorization, given the dimension of the problem?

Dr. BANSMER. No. I think it is a reasonable amount. I think it is between what would be ideal and what you could get. However, I do not think that money alone is the answer, but I think that more money right now is needed, I mean, you have got a pretty good vehicle, and all you are going to do is put an adequate supply of gas in it.

Senator KENNEDY. Which it is not getting.

Dr. BANSMER. Yes; I made the point before, that part of the unevenness, part of the skimpiness of some of the programs is an attempt to stretch the dollars, and I think they are doing very well with the dollars that they have.

Senator KENNEDY. Do you have any comment you want to make about that hospitalization—I think you have incorporated your views about its importance.

Dr. BANSMER. Well, if we speak about this totality of care, and then speak with migrants, they say the very first thing that concerns them is their acute and crisis care, if there is no acute care this engenders panic and hostility.

The HSMHA policy, that totality of care—now is leaving out the principal ingredient, hospitalization. People will not buy preventive programs just because they are there and because it is right.

You have to build a bridge to get them involved. Most of these people are unfamiliar with medical care and they are frightened of it. You have to build a bridge of communication and a bridge of understanding and a bridge of trust. Caring for them during their times of need builds trust and brings them into preventive care programs.

We recently came back from Michigan. We saw people who only go to a physician at some time of great crisis. They have never been immunized. They have had no preventive programs.

When they overcome this fear, they will accept preventive care, and the way you can best build that bridge is to come to their help at a time of their need, and you cannot do that without hospital care.

Senator KENNEDY. What is your reaction to the suggestion of HEW that we need to study these programs?

Dr. BANSMER. My own thinking is that we have enough studies on the record; and there are enough research and development programs that have gone on in the past. I think that what we have to do now is put up working models. There are any number of working models that have already been described. The only way you are going to find out is now to actually put them out, and float them and see how they go.

I do not think we should go out and institute a single nationwide system, but I think we do have some good local programs and now should do regional programs. We can expand local programs, and I think that the time now is to move into action. I think that they have been studied to death.

(Additional information supplied by Dr. Bansmer follows:)

YAKIMA VALLEY CLINIC
300 DIVISION STREET
GRANDVIEW, WASHINGTON 98930
TELEPHONE 882-3511 - AREA CODE 509

Gustav Bensmar, M.D., F.A.C.S.
Paul V. Gustafson, M.D., Ph.D.
Richard H. Layton, M.D.
Alfredo Lopez, MBDEX

Jack L. Quinn, General Manager

August 22, 1972

Stewart E. McClure
Staff Director
Labor and Public Welfare Committee
Room 4230, New Senate Office Building
Washington, D. C. 20510

Dear Mister McClure:

Upon my return and reflecting back upon our recent meeting, here are some of the thoughts that have come to mind.

First of all, in reading the throw away literature that is printed by various organizations, some of them historically conservative, others attempting to be objective and others hard to determine what their background is.

The first thing that you encounter in reading numerous critics of the present time and the present situation is that they try to deny that there is a crisis in medicine. We have to recognize that there is technical excellence in medicine---the real crisis is an economic one, namely, is the excellence and the cost of that excellence outstripping the ability of the market to pay for it. The market is the general population of the United States. These people who are so critical and who are trying to forestall the developement of HMOs or HSOs are attacking the wrong side of the question.

I think we should recognize that there is technical excellence in medicine and that this will continue, but the real crisis is an economic one and that we are now exceeding the ability of people to pay.

It seems to me that the next requirement is to then adjust the method of payment so that we keep all of these programs within the economic capability of all people. Although we spoke of the plight of the migrent, as I look at the people in our own practice the greatest dilemma, they face is not the ability to acquire medical care or that we are terribly limited in our physical ability to deliver it; rather it is their increasingly diminished ability to pay for it.

We now find people even in the so-called middle income groups doing without some programs simply because of their costs. The other thing that we see is the catastrophic effect of the generally inadequate insurance programing that is available to these people. There are good

programs in some of the major labor unions, but for the average individual who does not have access to this, the programs in general are quite poor. Again the basis of this is economic. Most of these policies are sold by commerical insurance companies and they have a profit ratio that they want to maintain and they would like to increase their earnings. Many of the policies that are available at the present time are overly costly and they are aimed at the concept that people can continue to pay an ever increasing premium. We, ourselves, in writing new insurance contracts for ourselves and our employees are painfully aware of how high the cost is in relationship to the benefits that are delivered. And for the time being, we can afford these things and perhaps our organization can afford these things better than others. It does create an ever more severe economic burden and certainly for any business that is marginal this could mean disaster and limit the ability of these organizations to furnish health and accident care as a fringe benefit of employment. My point is the economic crisis is not limited to the low income groups.

The next item that has intrigued me has been, how does one evaluate these programs. I think that we have almost exhausted the information that we can obtain by abstract research. I feel ever more strongly that the only way we are actually going to determine these programs is by putting programs into place, using the best guidelines that we have, but setting up model programs so that we can see how they actually work.

One of the great intangibles that none of the abstract research has as yet been able to evaluate has been patient acceptance and utilization. At the present time, without either HMO or HSO concept there is no effort being made for establishing a means of educating the public (the consumers of health care) about the limitations that they impose on themselves by over utilization and mis-utilization. Just as much as I feel we cannot make these things economically stable until we add the physician into the system where he shares risks, but equally as providers must be involved in financial risk sharing. I think that the consuming public must also recognize that they have a share. The only workable answer to this is broad scale education in the machanics of the medical-economic problems that these organizations will require. From my own experience at Group Health I feel that this is a very possible effort and that the patient population can be taught the prudent use of both the physical as well as the economic resources of an organization.

Then in summary in this area I would like to emphasize again that the next move is to develope at least trial programs and put them in place. I think that the next five years certainly in migrant division ought to be devoted to utilizing our resources to develope demonstration programs so that we can see what adjustments have to be made. To me the most important thing in getting these programs underway is to first recognize that we are dealing with a economic crisis, not with a technical crisis. Once we make the commitment we will find we can make these things work. The technical ability obviously does exist.

Another item that is constantly mentioned in the literature is the use of computers. The great hope that computers would save much manpower and manhours, I think is not going to be realized. The advantages that technology offers are real, but they are more in the area of being able to reach a larger group and simply add more work that we should be doing anyway. This we are not able to do if we are limited by what we can do by direct contact.

The idea that computers would replace manpower, I think is about as fallacious as assuming that agriculture will become a completely mechanical industry. The effective technological improvement especially the use of computers, making it possible for us to do the job we should be doing anyway and we are simply unable to do because we had to try to cover so much physical ground and therefore had to decide who needs the service most and let the others wait until some great problem arose.

The concept that computers and technology are going to make unnecessary the need for a new system of delivery of medical care is entirely irrelevant and has nothing to do with the situation.

In it's simplest form the crisis that we face at the present time is one of economics and that we are not going to solve this problem until we put programs into place to see how they function in actual practice.

In brief recapitulation:

1. There is a crisis in medicine---it is economic

2. There is a crisis of mal-distribution which is related to the economic problems most severe in rural and central city areas.

3. It is urgent that experimental programs be put into place---abstract research has been essentially exhausted. What is needed is operational experience.

4. Computers, data banking, research and retrieval will not relieve the manpower need. Good technology actually expands the need for human services---services that are not now being delivered.

5. Cost of medical care will not be reduced---but its usefullness can be increased many fold by equitable and efficient re-direction.

Sincerely,

Gustav Bansmer M.D.

Gustav Bansmer, M.D.

GB:rrb

Senator KENNEDY. Thank you very much. You have been very helpful.

Our final panel today consists of two attorneys who have worked with specific programs of residency requirements.

We are happy to have Mr. Joe Segor, from Miami, Fla., and Miss Miriam Guido, of the Migrant Legal Action program.

Mr. Elija Baines is accompanying Mr. Segor.

We are going to recess for 10 minutes. I have to go vote, and then we will come back and complete this.

(Short recess.)

Senator KENNEDY. The subcommittee will come to order.

We welcome you and apologize for the interruption.

You can proceed.

STATEMENT OF JOE SEGOR, ATTORNEY, MIGRANT SERVICES, MIAMI, FLA., ACCOMPANIED BY ELISHA BAINES AND MIRIAM GUIDO, ATTORNEY, MIGRANT LEGAL ACTION PROGRAM, INC., WASHINGTON, D.C.

Mr. SEGOR. Thank you very much.

I am not going to read my prepared statement.

Senator KENNEDY. We will include it all in the record at the end of your testimony.

Mr. SEGOR. To begin with, the issue I would like to touch upon is of course the continuation of the present act, an extension of it for 5 years.

I heard some testimony this morning regarding a mere 2-year extension. I think that we need continuity. We in the field need the right to know there is going to be a program for the foreseeable future so we can build upon our present advances and move on into the future.

I think 5 years is a reasonable period.

If during that period of time it should be discovered that there are some shortcomings in the legislation, you can always amend the legislation as those shortcomings come up. But we need that long-range funding.

All we hear and all you have heard today in the testimony is that the farmworkers are told wait, wait, and they always wait.

But in the meanwhile children are born without medical care and adults and children die without medical care. And the time now, as you have been told by the other witnesses today, is to act.

You have also been told there is unequal access to health care in the rural areas, and this is so true in Florida, where I come from. It was not too many years ago that a local physician in, I believe it was, Lee County had to be used by the Florida Rural Legal Services at the time I was director of that program, to integrate his waiting room. He was handling welfare recipients, and rather than integrate, he dropped the welfare program. Those kinds of conditions are universal in the rural areas of our State, and they can only be dealt with—the farmworkers can only be dealt with if there is a program that is geared to their needs.

I feel that around the farmworker program you can build a rural medical system on the HMO or similar concept. You can add on, once you have a good board, but it cannot be in the hands of the health

department as it presently is. It must be in the hands of consumer corporations, controlled primarily by the recipients of the services, and so on.

By creating consumer boards and creating consumer corporations, you would take the programs outside of the State merit system, and you would be able to deal with the problems in a rational sort of way. I think that it would be important that you deal with this issue in the legislation, rather than leave it merely to the regulations of HEW.

I am certainly not satisfied and many of those who have studied the regulations are not satisfied with the present compromise in the regulations. I think at least, the legislation should signify preference for consumer boards. There may be instances, I certainly cannot speak——

Senator KENNEDY. We had in our HMO policy a preference for consumer-dominated boards, but we lost it in this committee in reporting out our bill.

It is different, perhaps, for this particular program—I think it is—but even a pretty liberal committee, was reluctant to give just the preference to consumer-dominated boards.

These are some of the problems we have, let alone what will happen on the Senate floor.

I think you are right and I think your position is correct, and I certainly support you.

Mr. SEGOR. I think it would be helpful for these problems in the field. There was some discussion before about the role of the Policy Board, and I think that it more of a canard that is raised by the medical profession, by those who do not want to see consumer control, rather than a reality.

In my experience, it is hestitancy of the Consumer Board to go as far as it should, which is more of a problem, rather than going too far. When you have providers on the Board, particularly when there has not been any good Board training, they tend to dominate; so there is much to be done. One of the suggestions I have in dealing with some of the problems is that there be created a corporation controlled by farmworkers throughout the country, a national corporation that would have a number of tasks, and one of them would be to go and implement the consumer setup in various local communities by sending out technicians, who can help local groups, farmworkers, and their friends, set up the corporations, and help write the proposals, give them their own technical backup.

I do not think bureaucracy is sufficient. Bureaucracy has its own political problems, as you well know, and farmworkers need an independent source.

This corporation can do several other things. It could conduct Board training and also conduct administrative training.

Because a man becomes clinic director does not mean he knows a thing about administering an organization. Very often doctors and lawyers think they can do everything, but they are not necessarily very good administrators.

There is great need for administrative training. That is training of local people who have been taken on a staff. Too often they end up with lower jobs without a career ladder. There should be requirements that they be trained, so they can take over some of these career positions, technical positions.

The training should be at such a level that their credentials are transferable, so if they move out of the area and wish to work in a hospital or some other area, their experience and training will be accepted and they will in fact be adequate to their task.

Finally, such a corporation could also perform much of the inspection and evaluation. And as part of that, I think one of the important things to have is the equivalent of what your big department stores have; that is, professional shoppers. In this case, we probably ought to have some professional patients who come around and see just exactly what happens when you sit in that waiting room.

If you and I walked in there and they knew we were an inspection team, you know we would see nothing but "A–1" treatment, but on a daily basis, the treatment can be quite different. Even in the consumer-controlled clinics, there is a tendency sometimes to be sloppy.

Senator KENNEDY. What do you think are the principal weaknesses on the medical society's program?

Are you familiar with any of those?

Mr. SEGOR. We do not have any. Primarily in Florida, at least the ones I am familiar with, there is one consumer-controlled one and the rest are health department. I have not run into it. I have run into some of the problems of medical societies, and I certainly would not want to see transference in our area from health department to medical society. That would be going from the frying pan into the fire.

I have related something of the problems we have had with health departments. The care in many instances is not good. There is no feeling for the consumer. This may be doing a disservice to some hard-working nurses and doctors as individuals, but in the programmatic way, the health department programs are wholly inadequate. They certainly do not fight for the funding and do what is necessary politically to improve the program.

Consumer boards, I think, will be freer in trying to exert pressure to expand the program, to improve it. I think the last witness had a point which tends to be overlooked. That is, under a consumer board and an independent corporation, the migrant health programs can be the core for an advancing and expanding rural health system, and they can become the core of an HMO system or something similar.

You can wrap onto them other programs that exist. You can take advantage of State and private funding, and then you can begin to deal with those people who have some money and who could pay a prepayment. In Immokalee, Fla., this past year, there was no private physician, no matter how rich you were. You had to go 40 miles to Naples, or had to go to the migrant clinic.

Had that clinic been able to set up an HMO, we might have broken through some barriers, gotten some wealthier people to support the clinic and that would have had a double effect. It would have given good political clout, and also higher service because the middle class is not going to be pushed around by bad service.

So I think in dealing with these rural clinics, we should keep that in mind.

Senator KENNEDY. That is a good suggestion.

Mr. SEGOR. The question of hospitalization, of course, is one that is just a tremendous problem in our State. I think the legislation should earmark funds for hospitalization. I recognize that you become

a third-party payor, but the farm workers need it so badly that I would take that risk and provide the funds on an immediate basis, which brings us, I suppose, to the funding levels.

I know the bill starts off with $100 million, which is a nice jump from the present approximately $18 million; but somebody said before—and I do not remember whether it was you, Mr. Chairman, or one of the witnesses—that the per capita expenditure under the $18 million is something like $5 a head.

I did some fast arithmetic, and if we brought that to half the average of, I understand, $200 per head, that most of us pay in medical services in the country, it would come out to something like—it would be a 20-fold increase or about $360 million. So even your figures are on the modest side.

In my prepared testimony I suggest a minimum of something like $200 million to make up the gap—and particularly if you get into hospitalization—$500 million would not be unrealistic. That seems to be supported by the testimony of the administration, which wanted a big $23.9 million.

That is ridiculous.

You know better than I the political and funding realities. I would say shoot as high as you can and $100 million should be the floor and not the ceiling, although I recognize that may be somewhat politically unrealistic.

There are some techniques that I would like to see written into the legislation. Farm workers, of course, as we all know, have the third highest rate of industrial accidents. Pesticide poisoning is one of the most important issues there, and I think it should be mandatory that every migrant and seasonal farm worker clinic set up a program of pesticide testing.

I also think, at least in the East, where we have a large number of blacks, that the expanding concept of sickle cell screening also should be looked into. That may not be a problem for legislation, but it is certainly important to our black population. I think that while the legislation talks about it, there ought to be more pressure for staff training, particularly for migrants and seasonals who become employed.

I know that there is some tendency in the heat of trying to do these examinations every 3 minutes of not having the time to train the staff, and that of course cuts into the career-ladder concept that I spoke to you about before. Pressure has to be put on to set aside time, funds, effort, for the career-ladder training.

The people at the lower end themselves become frustrated because they know something of what they want to do. They do not have the skills to accomplish their goals. You have got to give them those skills, and I think we may see some really surprising things happen in these rural areas when you combine will and drive with necessary technical skill.

Dr. Kruger, who is head of the clinic at Homestead, which is the only consumer clinic we have in Florida, suggested to me that one of the problems in recruiting physicians is State licensing procedures, and his suggestion is that by Federal law there be a 2-year waiver on State licensures, something like Pennsylvania does for legal services lawyers, I understand—gives them a 2-year moratorium, as long as they have a license in another State.

Then they would have to, during that period of time, have a State examination.

There is also a problem hanging over our heads and that is the veto that the local medical society has on national health service people.

We think at least for our migrant clinics, that that veto should not be allowed. I do not know whether you can do it in this legislation, but it is certainly to be looked into.

Again it has been suggested to me by a number of people that a national information system should be created to funnel the information from various projects together, and to create a communications network between all of the projects. This is particularly important for continuity of care so that the farm worker who starts out in Homestead, Fla., and moves to Ruskin, and goes out of the State, will have his records and his care with him along the stream.

There is also a need in the clinics for some emergency funds. People come to them and they may not have a place to sleep or food. You cannot treat a medical problem if the person is going to starve to death. We must through this legislation or other means strap in some emergency resources for the migrant clinics.

Finally, of course, I think there is a need to create a patient advocate system, and patricularly if the funding comes—if we expand the size of these clinics—then there should be one person on the staff, who will act as a patient ombudsman.

Even consumer control boards can be remote from the feelings of the patient, and there should be a means of bridging that gap. I would suggest it be made mandatory as far as the setup of any clinic of any size.

Thank you.

Senator KENNEDY. Very good. Very helpful comment.

(The prepared statement of Mr. Segor follows:)

STATEMENT OF
of
JOSEPH C. SEGOR, EXECUTIVE DIRECTOR
MIGRANT SERVICES FOUNDATION, INC.
on
THE MIGRANT HEALTH ACT
before the
SENATE SUBCOMMITTEE ON HEALTH
COMMITTEE ON LABOR AND PUBLIC WELFARE
AUGUST 1, 1972

My name is Joseph C. Segor, I am the Executive Director of the Migrant Services Foundation, Inc. With me is Elisha Baines, an officer of the Glades Citizens Association. Mr. Baines owns and operates a small grocery store in the town of Pahokee, Florida, which is situated on the southeastern shore of Lake Okeechobee. He has long been a civil rights activist, having openly stood up for the rights of his people during the years prior to the Civil Rights Acts of the Sixties, a time when it was physically dangerous for a black man to open his mouth in rural Florida.

The Migrant Services Foundation, Inc. (MSF), is a small non-profit charity entirely financed by private funds. We provide legal and other services to farmworker organizations in Florida. Prior to becoming Executive Director of MSF, I was Executive Director of Florida Rural Legal Services, Inc. I have worked exclusively with farmworkers for the past five years.

Mr. Chairman, I appreciate your invitation to testify before this Subcommittee, but in all candor I must say as I prepared this statement I was overcome by a sense of frustration and futility. Though Hope springs eternal, I could not help but feel, "Here we go again. Another hearing that will produce little or nothing in the way of fundamental change." I reflected that on a hot, sunny day in 1966 I shook your hand and talked with you about migrant problems as we stood on a dirt road in the middle of a deplorably dilapidated labor camp in

Dade County, Florida.

Lawyers under my direction prepared much of the testimony presented to the Select Committee on Nutrition and Human Needs when it held hearings in Immokalee and Fort Myers, Florida, in March, 1969.

Almost exactly two years ago, July 21, 1970, to be exact, I testified before the Subcommittee on Migratory Labor about the condition of powerlessness suffered by farmworkers in our State. Part of my testimony concerned health programs. I told the Subcommittee that Polk County, which produces more citrus fruit than the entire State of California, did not have a Migrant Health Clinic because the local Health Department was unwilling to keep separate records for migrants and therefor was unable to comply with Federal Regulations. I am sorry to inform this Subcommittee that Polk County, known locally as Imperial Polk, still does not have a Migrant Clinic. Apparently the Imperium does not regard the health of the men, women and children whose labor produces much of its wealth, a matter for royal concern.

I also told the Migratory Labor Subcommittee about the attempt of a doctor from the University of Miami Medical School to set up in Immokalee, the principal farming community in agriculturally rich Collier County, a major clinic under the Migrant Health Act. His efforts came to naught when local doctors told the people at a public meeting that what was needed was a hospital and not a clinic. This statement, created considerable excitement and the clinic idea was quickly forgotten.

A Committee was appointed under the Chairmanship of the one private physician in Immokalee to formulate plans and raise the money for the hospital. This physician, along with the local druggist, had been prime opponents of the clinic. I stated in 1970, "Little or nothing has been done to further the hospital in the year that has elapsed and the clinic will

be located in the more hospitable climate of Dade County."

In 1972 I can report to you that nothing has been done about the hospital, the large farmworker community in Immokalee still suffers its wounds and illnesses to be treated at a wholly inadequate clinic, and the Martin Luther King, Jr. Clinica Campesina, with its half-million dollar budget, is operating under a full load in Dade County. I can also report that the Collier County Health Director has stated that he might recommend giving up Migrant Health Act money if Federal Regulations calling for a Project Policy Board are implemented." This arrogant and stubborn man is willing to surrender the clinic's primary source of funds rather than give up some of his power to the community he supposedly serves.

There is good reason for him to fear an active Policy Board. Under the regulations, which incidentally I consider inadequate, the Board would choose the Clinic Director. Under the present administration a National Health Service physician who did a terrific job and was well-liked by the community was forced to ask for a transfer. At one point the clinic ran out of medicine and needed equipment was stored without being used. The clinic administrator works forty miles away in Naples and is rarely seen in Immokalee. None of the staff physicians live in the community. Although malnutrition is a constant problem, the clinic does not purchase vitamins, but must rely on donations. Some of the staff harbor attitudes that are antagonistic toward the clinic's patients, most of whom are black or chicano. It is doubtful if a Project Policy Board composed principally of farmworkers would tolerate such conditions for very long.

In 1970 I testified that the principal source of discontent with consumer control in Dade County was the local Health Department. When the Martin Luther King, Jr. Clinica Campesina opened up, the Health Department pulled

its nurses out of the migrant camps. As a result, there is today less well-baby care than there was prior to the coming of the Clinic.

Problems with Health Department-run projects abound. In Hendry County, only one black is employed by the Health Department despite the fact that a majority of the farmworkers are black. Transportation to and from the clinic is non-existent and the level of services grossly inadequate. The farmworkers have no say in the planning or operation of the project.

In Delray Beach in Palm Beach County, some of the farmworkers travel to Pompano, thirty miles away in Broward County, to receive care, rather than suffer callous treatment from the staff. I am told that the Delray Clinic acts as a collection agent for the local hospital. Expectant mothers are not referred to the hospital unless they have the $275.00 fee. Staff members of one Federally-funded agency tell their clients to go directly to the hospital emergency room and not bother with the clinic.

Despite the present short-comings of the clinics operated under the Migrant Health Act, I believe that it is imperative that Congress continue to finance categorical assistance to the migrants. Even if National Health Insurance comes into being in one form or another, migrants probably won't be able to take advantage of it. There is a tremendous shortage of physicians, nurses, medical technicians and hospital facilities in rural areas.

A week ago Sunday, a quarter-page ad. appeared in the Sports Section of the Miami Herald placed by a Committee of Citizens from Manatee County, including the president of a bank, a savings and loan association and the County Medical Society. The ad. promised general practitioners and internists an income of forty to fifty thousand dollars per year if they would relocate to the town of Palmetto. You might think that

Palmetto is located deep in the boondocks, far from the amenities of urban civilization. On the contrary, it is four miles from the tourist town of Bradenton, fifteen miles from Sarasota with its beaches, fine restaurants and legitimate theatre, and thirty miles from the Tampa-St. Petersburg complex, the State's second largest urban area.

If towns such as Palmetto must advertise, what must Immokalee and Belle Glade do? I believe that in order to attract physicians and other health care people to such areas, we must do more than promise high incomes. We must create institutions that will give the individual employee a great deal of satisfaction. We must seek out the people who want to serve, and I believe there are many of those. We must make special efforts to do this, and the task can only be accomplished if funds are specially earmarked for the purpose.

There is still another reason why migrants should be dealt with as a special group rather than as just another sub-group of the general population. The migratory experience has a peculiar effect on migrant people, especially the children. It uproots and isolates. It creates feelings of suspicion, inadequacy and hostility, and fosters the attitude that times are hard and nothing can be done about it. It is therefor necessary to do more than just make a service available. There must be extensive efforts to reach the migrant community. Means must be found to bridge language, educational and cultural gaps. Account must be taken of the fact that the migrant may move on before treatment is completed. There are special occupational disease problems that have yet to be confronted and most certainly will not be dealt with in the future if Congress does not mandate it.

Dr. Leon Kruger, Director of the Martin Luther King, Jr. Clinica Campesina in Homestead, has told me that the best way to provide migrants with health education is through positive experience with a health unit. Abstract education, he says, through books or lectures does not work very well. First-rate treatment in a warm atmosphere can do wonders. Dr. Kruger believes that a number of families have stopped migrating primarily because of the health care provided by the Homestead Clinic.

Merely providing special migrant funds is not sufficient, however. Careful attention must be paid to who spends the funds and how they do it. I have mentioned the serious difficulties that farmworkers have had with Health Departments in several counties. I believe that migrants will be best served if Migrant Health Act funds are channelled to grantees other than the Health Departments. Such grantees should be controlled by Policy Boards, a majority of whose members are migrant or seasonal farmworkers, with at least some seats guaranteed for migrants. The present regulation requiring that 51% of the members of the Board be chosen by the population served is inadequate. It is conceivable that under this provision a Board could be created without migrants whatsoever. It is my understanding that in some Florida counties, the Health Department is going around getting gullible farm workers to sign waivers divesting them of the right to have a Policy Board.

Such shenanigans must be stopped. The Board selection process should be used as a means of advertising the existence of services and educating the people about health care issues. To ensure that truly representative Boards are created and that the Board members are adequately trained to carry our their tasks, a farmworker-controlled grantee should be funded. This grantee will advise farmworkers in the various local communities about how to set up a health program. Help write proposals, conduct elections, provide a clearinghouse for health

care personnel who wish to work with migrants, provide Board training, provide Staff training in administration and evaluate the project. As part of the evaluation process I would suggest a system analagous to the professional shoppers used by some stores. Evaluators disguised as migrant patients should seek to obtain services from projects. Complaints of callous and prejudiced treatment by staff are ubiquitous and a system such as I suggest might go far to eliminate them.

One of the problems with categorical assistance is that it tends to separate the selected group from their fellows, many of whom may have similar problems and difficulties. In rural areas the motel maid, the gas station attendant and the grocery store stockman may not have any more income than the farmworker and may suffer equally from lack of access to medical services. As I have indicated, merely merging migrants into an overall medical system is not sufficient.

There is a way, however, to deal with the health problems of the migrants and the rest of the rural poor. That is, use the Migrant Health Act grantee as the core of a Rural Health Maintenance Organization. HMO's are not without their own short-comings. For one, I believe that HMO's should not be profit-making. When profits are there to be made, their maximization tends to become the goal, rather than provision of the best possible service at the lowest possible cost.

Since Migrant Health Act grantees will be non-profit, this objection does not apply to them. The Migrant Health Act funds can be used as the seed money to start the HMO. Medicare, Medicaid and private insurance can be used to defray part of the expense of the facility, while grants can be sought under other Federal and State programs. Those in the community who can afford to pay can be allowed to do so, preferably on a pre-paid basis. In many rural communities, middle-class members

of minority groups find it hard to get service locally. I am sure many of them would be happy to pay to get first-rate care in their own community. This past year in Immokalee there was not a single private physician. The wealthy as well as the poor had to either use the Migrant Clinic or travel forty miles to Naples where the physicians are so busy that I understand they use a quota system. I suspect that many of those who can afford to pay, white as well as black and brown, would join an HMO set up around a Migrant Health Act core. Not only would the middle-class benefit, but the migrants would also gain from the inevitable middle-class insistence on quality care and courteous service.

An area that requires immediate attention is the need for funds to pay for hospitalization, nursing home care, and special treatment that cannot be provided by the Migrant Health Act facility. Despite the Hill-Burton requirement that Federally-financed hospitals must provide care to indigents, farmworkers find it virtually impossible to get into a hospital except on an emergency basis, and there are numerous reported cases where even emergencies have been turned-away. This tragic situation must be remedied immediately. There is no telling how many farmworkers have been crippled or have lost their lives because they could not get into a hospital or receive aid from a specialist. From the reports that I have received over the years, the number must be immense.

Although the present Act does not prohibit use of funds for these purposes, it is my understanding that no money is used for hospitalization and very little for specialist care. Substantial funds should be earmarked for these purposes as well as nursing care.

This brings me to the whole question of funding levels. Congress authorized $25-Million for 1972 and appropriated $17,950,000 or approximately $7.50 per migrant. Words fail and I cannot adequately express my emotions when I look at these figures. What

kind of Nation is this, what kind of people make up this Congress when the health of the people who harvest the food that sustains our lives is valued at only $7.50 per head. A hundred million would not be enough, two hundred million would bring the migrant to the national average, five hundred million might begin to make up for the past inadequacies. Whatever you do, don't toss the hardest-working poor people in the Nation the bone of $7.50 per head. That is just being cruel.

Before closing, I would like to quickly cover a number of areas that should be specifically covered in the legislation.

Farmworkers have the third-highest rate of industrial accidents. They are especially subject to pesticide exposure. Funds should be provided for routine pesticide level testing. In addition to testing workers, projects should monitor pesticide levels in the field and should check safety practices. Recent research tends to indicate that pesticide levels may build up in the body to such an extent that continued exposure would cause serious injury or death. Persons who reach this level should be deemed medically disabled from further participation in agriculture and compensated accordingly.

Outreach is vital to migrant facilities. More funds should be provided for vehicles and outreach workers.

Formal programs of staff training are another important need. Minority group members who are recruited into projects should be given the opportunity to climb career ladders. Their training should be such that it will be recognized by other segments of the health care community, thereby allowing them to continue in the health care field should they leave the Migrant Project. A dual leadership system should be established whereby community people work with and are trained, especially for administration, by specialists and then take over the specialists' jobs.

A system of communication between projects must be worked out. Continuity of care cannot be maintained without such a system.

Physicians working in migrant programs should not be hindered by State licensing requirements. By Federal Act they should be given two years in which to achieve State licensure.

National Health Service Personnel should not be subject to veto by the local medical society. The rights of the consumer should be paramount.

Suitable clinic sites do not exist in some communities. Funds should be provided for construction or the purchase of modular units.

A Standard Information System should be established. A Central Office should receive weekly encounter reports from the projects and tabulate them.

An Incentive Program should be developed to encourage health care personnel to join in the projects. If the proper combination of money and imagination could be developed the Migrant Program might serve as the basis for a renaissance in rural health care.

Emergency Funds are needed for food, rent and other family needs. Social Services should be available at the project site or nearby. Funds to accomplish this should be provided.

Sickle cell trait screening should be performed on all black patients and treatment or counselling given to all those found to have the trait or to be suffering from the disease.

A Patient Advocate System should be established for each facility and patient complaints, suggestions and opinions routinely solicited.

Informed consent should be required for all scientific

experimentation.

Provision should be made for waiver of local share, especially in those locales where there may be hostility toward the project.

Agdin let me thank you for the invitation to testify here today. It is my fervent hope that your labors will enable farmworkers to enter into a new era of healthful living.

-0-0-0-0-

pp 108-109 deleted (material illegible)

Mr. BAINES. My name is Elisha Baines.

The first thing I want to say is that one dirty word that I hear people use all the time and I heard it today is "migrant."

That word hurts me more than anything else. If we could use the word "poor" instead of migrant.

We have been deprived of a great service by using that word, "migrant," because it has so many existing programs that does not touch the poor man because he is not a migrant. I once was a migrant. I went up and down the stream. But I stopped going, and I know some people that are poorer than the migrants—some of them get so old until they cannot migrate; and he is not considered a migrant. And then what are you going to do with that poor man, or family?

That word "migrant," if we can get that away from our program, we would do a lot of our people a great deal more service.

You take the medicaid patient. Most doctors in my town do not accept medicaid patients. They have got big signs "No Medicaid Patients." They say the State does not pay them. They say it is too much paperwork.

Now, we need to do something about these people, because it disturbs me because some people—where I live it is 40 to 50 miles to West Palm Beach, where you might see a doctor, but they cannot see them because they do not have no money to pay nobody to take them there.

And the $20 that they are allowed for medicine, the first time some patient goes to one of these doctors, they take all of that, and he cannot have his prescriptions refilled because they do not have the money.

And the health department clinics, I do not know what to say. They are inadequate or do not have enough service or do not have enough of them. They are not reaching the people. When something is not reaching the people, then why not expand to something else?

And to get to a clinic, you have to have a certain kind of nurse to get a slip, and on the weekend you cannot get a slip, and that same person— well, he has got to wait until Monday or Tuesday before he can get a slip to go to the doctor, and often he is dead before that times comes around if he is real sick.

Transportation is something else that is real bad for our older citizens. You do not have to be old. You just have to be too poor to hire anybody. It is bad. You cannot get from one place to another. And all the facilities are sometimes 4, 5, or 20 or 30 or 40 miles from them.

I think I sometimes—well, I do not know, but I think some kind of compensation laws should be passed for the farmer, because most of the people are not covered for, especially, pieceworkers. There is just something that is just left alone, I would say, almost, or he is forgotten man, or forgotten women.

My mother put me in a little insurance almost 50 years ago, I think it paid me off a few years ago, and it paid me $200 or $300. Therefore, these little things work on our poor people that have not had the experience of that. So this legislation needs to pass something to make it mandatory for these big farmers to carry insurance on these people, workmen's compensation, or something to be paid.

So often now, sometimes people die, and here is somebody that goes around with a hat or something and trying to get money enough to bury them. In small rural areas, the burial charge is much more than

it is in the cities. Most of the small rural areas do not have but one undertaker there, and maybe 40 or 50 miles from there. All of these things, they fall on the little man.

I had the experience here for the last year and a half, almost 2 years, a group of people came down from OEO and they invited a group of citizens down and wanted to know our needs.

We told them that we needed more doctors or a clinic or something; and we organized what you call rural health committee, and we worked on this program for the last year, going here and yonder. We were made to believe at that time that they were going to be funded, that we were going to be an umbrella agency. And after working and having four or five investigations with people coming down from here so much, investigators to see where we stood, who we were and everything, coming up to funding time, just before funding time, they told us that we could not have the money because we did not know how to handle money.

If you have never had money, how are you going to know how to handle it?

I see different people in office here, but before you were elected in office, you had never served in this capacity before, and this is what we were told, and that really hurt.

Then they told us they had contacted the university to handle our funds and be our grantee, and we would have to go to them when we needed money.

I thought I left that when I got to be a man, that I stop asking my mother for a nickel or a dime, but to find out that is what we have got to go back and start doing there.

But anyway, the university agreed to be the grantee for this money. Then we run into the health planning council. This is a group in my county that, if they do not think a program should come there, they do not come. In other words, it is about 10 or 12 men, which I am a member of—and when they put a black man on the board, he is just there have got to go back and start doing there.

I found out when they get something, they have to use a minority, but he is there, and they said that we did not need a clinic, that we had everything that we needed.

They live 40 or 50 miles from there, and we have to suffer because they just decide, well, you do not need nothing. That is all, you do not need nothing.

However, after a long fight, we finally got the approval of the health planning council, and we are supposed to start—let me say it that way—supposed to start laying the groundwork in the next 2 or 3 months. I hope something can be done to speed this up.

Thank you.

Senator KENNEDY. Thank you very much. It is quite a different dimension from what we had this morning because you have related your personal experience, and I think it is very much appreciated.

Ms. Guido.

Ms. GUIDO. My name is Miriam Guido, and I am a staff attorney for the migrant legal action program in Washington, D.C.

As the last witness, I intend to summarize my statement as quickly as I can.

The first point we would like to make has come up many times today, although not precisely in this form: It ought to be recognized that the national health care programs which are intended to cover the whole population do not cover migrants.

The first program you have to deal with is medicaid.

One of the problems with medicaid is the residency requirement which was brought up earlier.

Senator KENNEDY. Can you give us suggested amendments on the medicare-medicaid programs so we could amend the system so it would broaden to cover the poor? There is a distinction I would say, in the legal definition between the migrant and the poor. I agree with your philosophical approach 100 percent.

Ms. GUIDO. In order to deal with medicaid you must first deal with the tie to categorical assistance. Many States limit medicaid to persons who receive other categorical assistance; that is to say that you have to have a broken family; or you have to be unemployed before you can receive any help at all.

Senator KENNEDY. If you could do that for us, just analyze it and give us your statement on it.

Ms. GUIDO. The second program you must examine is medicare. I think the basic problem here is that the program is tied to social security coverage, which I could cover in further written testimony, if you prefer.

Senator KENNEDY. Give us some suggestions on those, too, the ideas that you have for piecework versus general salary work.

(The material referred to follows:)

SUGGESTED AMENDMENTS TO THE MEDICARE-MEDICAID PROGRAMS TO EXTEND MIGRANT WORKER COVERAGE UNDER THEM

1. MEDICARE

a) Amend the Medicare Legislation, 42 USC 1395(c), to eliminate the requirement that persons over 65 must be insured for cash benefits under either the Social Security or the Railroad Retirement Program in order to be eligible for hospital insurance protection.

b) And/or pass a bill amending the Medicare Legislation, 42 USC 1395(c), to provide "Hospital Insurance Benefits For Uninsured Individuals Not Otherwise Eligible." This bill would "make available hospital insurance coverage on a voluntary basis to persons age 65 and over, including civil service annuitants and their spouses, who are not entitled to such coverage under existing law. A State or any other public or private organization would be permitted to purchase such protection on a group basis for its retired or active employees age 65 and over. The intent is that the cost of such coverage would be fully financed by those who elect to enroll for this protection. Enrollees would pay a monthly premium based on the cost of hospital insurance protection for the uninsured group; such premium would be $27 a month beginning with July 1971 and

up to and including June 1972, and would be recomputed each year and increased in the same proportion as the inpatient hospital deductible" (Social Security Amendments of 1970, Committee on Finance, Senate, 91st Cong., 2nd. session, Report No. 91-1431 at page 95).

2. MEDICAID

a) Amend the Medicaid Legislation, 42 USC 1396, to include a requirement that all participating states provide Medicaid benefits for the medically needy as well as for those persons already receiving assistance under state categorical grants.

b) Amend the Medicaid legislation, 42 USC 1396, to include a requirement that all participating states provide Medicaid benefits to all persons present in the state who are medically needy regardless of their permanent place of residence.

Ms. GUIDO. I would like to amplify my statement regarding medicare.

There is a very serious problem with the coverage of migrants under the social security program. A great many migrants are not covered as is recognized, by the Social Security Administration, and therefore, as long as you are going to limit medicare coverage to social security coverage you are almost telling migrants they are never going to receive medicare benefits.

The third problem in terms of general health care programs is obviously hospital care, which has been brought up so many times today, that I do not think it is necessary to discuss it further.

However, some comment is necessary on the Hill-Burton regulations, which might have been very helpful, if they had not been successfully opposed by the health providers who are not totally happy with free health care being provided to people who cannot pay.

Senator KENNEDY. Why not file a suit on that?

Ms. GUIDO. I believe that the National Health and Environmental law program is taking steps in that direction. However, the conclusion which you must reach is that if we are going to cover migrants under this program, or if we are going to cover migrants under an HMO program, we have to be exceedingly careful not to run into any of the problems that have been encountered in every other national health care program.

My own feeling is that we should probably cover migrants under the Migrant Health Act, and the Migrant Health Act should be incorporated into other national health legislation, rather than being replaced by this legislation.

In terms of funding, I think the figure of $100 million is to be commended. Although it is clear that more is needed, if that is the practical limit, you should definitely attempt to get that and no less.

I have a study which was done for OEO, where it was found that a family of five received $15.05 per year in migrant health programs. That figure is closer to $3 per person than the figure of $5 per person which was referred to earlier, which is to say the situation may be even worse than it appears to be.

The second point I would like to discuss concerns the regulations that were recently passed. We commened the fact that these regulations were passed. I think they will make a great deal of difference in terms of implementing the act, so that people will have some direction to follow when they are attempting to determine whether or not their actions are correct, or whether their actions will lead to the provision of services for their clients.

However, I believe that the enforcement of the regulations is extremely significant, especially as it is not entirely clear whether or not HEW intends to require rigid enforcement of the regulations. I think that enforcement ought to be stressed.

Rather than patting somebody on the hands and saying: You ought to comply with the regulations. HEW should defund several of the worst projects, especially projects which are clearly not going to comply with the regulations such as the one in Immokalee, Fla., where the director has said he does not want any community participation.

There are several sections in the regulations which should be clarified:

The first is in section 56.106(a)3, that deals with the aspects of care that have to be delivered.

One section requires that four specific aspects of care must be delivered or arranged for, while another section requires that three other services be arranged for. Clarification is necessary to determine which of the services in the first section can be arranged by the project and paid for by the client, and which services must be paid for by the project.

A second problem with the regulations is found in the section which allows a project to avoid compliance with the community participation requirements, where there is inconsistent State or local law.

In that situation, the project is forced to provide alternate procedures to those which are laid out in the regulations.

However, this alternate procedure should be defined as to exactly what it can or cannot include. Otherwise, it can become an empty letter.

There is also an unlimited time to remedy the legal disability which is involved, and this time period should also be defined and limited.

Mr. SCHNEIDER. Let me say in the questions that the Senator stated he was going to submit to HEW, those two points are covered specifically; so we will have some feedback from HEW on reasonable time and what services will be considered to be required to be delivered by the migrant health program.

Ms. GUIDO. I think that is very important.

Another problem with the regulations concerns the amendments to the regulations. The regulations were amended so that the board can be elected by, rather than from and by, the community to be served.

I believe that this change creates serious problems of paternalism, insofar as it results in the representatives of migrants deciding what kind of care should be delivered to migrants, as opposed to having migrant consumers themselves decide these factors.

Finally, the guidelines to the regulations should deal with two additional factors. The first problem refers to continuity of care, which has been recognized by everybody to be a problem, for which there is no obvious solution.

The regulations provide that continuity of care should be provided, but they do not say how.

The second problem can be solved by instituting a quorum requirement for the board meetings, requiring that 50 percent of the people at the meetings be from those elected by the community, thereby avoiding the situation of railroading the community by not informing them of the meetings, or by scheduling meetings when they cannot possibly attend.

The last point that I wish to bring up has already been commented on by Senator Kennedy: That is to give an express preference in funding decisions to community-sponsored projects rather than to State or local public health department projects.

Mr. SCHNEIDER. Let me say we do hope to amend the legislation to that extent.

Ms. GUIDO. I hope you are successful.

I think the community change study which has been mentioned several times today makes it abundantly clear that a community group will provide much more comprehensive care, will be much more likely to provide community participation, and will be more successful in any other quality indicator than any other sponsor.

I think it is important to note in this respect that the public health departments were originally designed to deal with preventive health care, including immunizations and communicable diseases, and therefore to ask them to provide the kind of comprehensive health care that should be provided under the Migrant Health Act is obviously inappropriate.

Another problem that must be dealt with in regard to funding decisions is the conflict between a community grant proposal and a grower or growers' association grant proposal. In that kind of situation the community group should also be given a preference in funding, because it is obvious that an employer and employee are going to have a conflict of interest, because of the respective positions that they fulfill; and this conflict of interest only adds to the existing problems with migrant health.

As the Department of HEW doesn't seem to have any funding preference for community groups, this legislation is all the more necessary.

Two examples should suffice to illustrate HEW's attitude. One occurred in the State of Oregon where the Valley Migrant League submitted a proposal statewide. This proposal was made in response to a decision by the regional office that the State should no longer handle the grant. However, the ultimate result was that the State will have the whole grant for the next 6 months, after which the community group will be given one county.

A similar situation has occurred in the Massachusetts and Connecticut area where a growers' association asked for $125,000, while a community group intending to cover both Massachusetts and Connecticut asked for twice that amount. The final decision was to split the grant, thereby giving the community group half of what it wanted and giving the growers association all of what it asked for.

Obviously the community could not accept this kind of offer.

My last point regards technical assistance.

This has been discussed today, but I think it should be emphasized that technical assistance is absolutely necessary if you are going to have grassroots or community groups forming projects.

It is obvious that they will need aid both in writing the proposals and later in implementing them. Although some technical assistance is now provided, it is not entirely clear that it is provided in a nondiscriminatory fashion.

Specifically, it was asked that technical assistance be given to a group in Immokalee, Fla., but this assistance was denied on the basis that only the regional offices could give such aid, with full knowledge that the region would not give such aid to this group.

The only solution is to provide technical assistance through the Washington office so that local political problems do not enter into the funding decision.

Thank you for the opportunity to testify today.

Mr. SCHNEIDER. Thank you.

The subcommittee stands in recess.

(Whereupon, at 2:11 p.m., the hearing in the above-entitled matter was recessed.)

APPENDIX A

Calendar No. 1013

92D CONGRESS
2D SESSION

S. 3762

[Report No. 92–1063]

IN THE SENATE OF THE UNITED STATES

JUNE 28, 1972

Mr. KENNEDY (for himself, Mr. CRANSTON, Mr. DOMINICK, Mr. HUGHES, Mr. JAVITS, Mr. MONDALE, Mr. NELSON, Mr. PELL, Mr. RANDOLPH, Mr. STEVENSON, and Mr. WILLIAMS) introduced the following bill; which was read twice and referred to the Committee on Labor and Public Welfare

AUGUST 16, 1972

Reported by Mr. KENNEDY, with an amendment

[Strike out all after the enacting clause and insert the part printed in italic]

A BILL

To extend the program for health services for domestic agricultural migrant workers.

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 "$30,000,000 for the fiscal year ending June 30, 1972," and inserting in lieu thereof "not to exceed $100,000,000 for the fiscal year ending June 30, 1973, $125,000,000 for the fiscal year ending June 30, 1974, $150,000,000 for the fiscal year ending June 30, 1975, $175,000,000 for the fiscal year ending June 30,~~

II

~~1976, and $200,000,000 for the fiscal year ending June 30, 1977".~~

That section 310 of the Public Health Service Act is amended by striking out "$30,000,000 for the fiscal year ending June 30, 1973," and inserting in lieu thereof "not to exceed $60,000,000 for the fiscal year ending June 30, 1973, $105,000,000 for the fiscal year ending June 30, 1974, and $120,000,000 for the fiscal year ending June 30, 1975".

SEC. 2. Section 310 of the Public Health Service Act is further amended by striking "and" immediately before the clause designation "(ii)" in paragraph (1) and inserting at the end of such clause the following: "and (iii) premiums for a prepaid health care plan eligible for Federal assistance where such clinics or special projects so request. All such clinics, special projects, and prepaid health care plans shall provide out-reach and follow-up services;".

SEC. 3. Section 310 of the Public Health Service Act is further amended by inserting "(a)" immediately after the section designation and by adding at the end of such subsection the following new subsection:

"(b) There are hereby authorized to be appropriated $25,000,000 for the fiscal year ending June 30, 1973, $35,000,000 for the fiscal year ending June 30, 1974, and $40,000,000 for the fiscal year ending June 30, 1975, to enable the Secretary to assist in the provision of necessary

hospital care to domestic agricultural migratory workers and their families."

SEC. 4. Section 310 of the Public Health Service Act is further amended by adding at the end of new subsection (b) the following new subsection:

"(c) In making grants under this section the Secretary shall give priority to those applicants whose policy-making body is composed of a majority of persons who are consumers of its services, where competing applicants appear to the Secretary of Health, Education, and Welfare to be equally qualified."

Calendar No. 1013

92D CONGRESS
2d Session

SENATE

REPORT
No. 92-1063

THE DOMESTIC AND SEASONAL FARM WORKER HEALTH ACT OF 1972

AUGUST 16, 1972.—Ordered to be printed

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

REPORT

[To accompany S. 3762]

The Committee on Labor and Public Welfare, to which was referred the bill (S. 3762) to amend the Public Health Service Act to extend the program of assistance for family health services for domestic agricultural migrant workers, and for those other purposes, having reported the same, report favorably thereon with an amendment and recommended that the bill as amended do pass.

I. SUMMARY

As reported by the Committee on Labor and Public Welfare, S. 3762 would extend until June 30, 1975, the authority of Section 310 of the Public Health Service Act to improve health services and the health conditions of domestic agricultural migratory and seasonal farm workers and their families.

This bill, as amended, does the following: (1) It extends the existing authorization from the June 30, 1973, expiration date through June 30, 1975. (2) It increases the authorization for Fiscal Year 1973 to $60 million, for Fiscal Year 1974 to $105 million and for Fiscal Year 1975 to $120 million. (3) It establishes a specific authorization of $20 million in Fiscal Year 1973, $35 million in Fiscal Year 1974 and $40 million in Fiscal Year 1975 for hospital care services. (4) It establishes a new authority permitting local projects and other eligible grantees to use funds for the costs of premiums for pre-paid health care plans where local grantees request such authorizations; and (5) It requires the Secretary, when making project grants under this act, to give priority to those grant applicants whose policy-making body is composed of a majority of persons who are recipients of those services.

II. Hearings

On August 2, 1972, the Senate Subcommittee on Health and the Senate Subcommittee on Migratory Labor jointly held hearings on S. 3762. Senators Edward M. Kennedy and Adlai E. Stevenson, III, chaired the public hearings during which sixteen witnesses, including the Department of Health, Education and Welfare, and others knowledgeable in matters related to the health status of the migrant and seasonal farm workers, testified. Outside witnesses included: Leo Garza, Director, Hidalgo-Starr Catholic Charities, Pilgrim House, San Juan, Texas; George Powell, Senior Supervisory Attorney, Texas Rural Legal Aid, Edinburg, Texas; Adon Juarez, Project Director, Orange Cove Clinica de Salubridad, Orange Cove, California; Johnny Johnston, Belle Glades, Florida; Ventura Huerta, Project Director Clinica de Salubridad de Campesinos, Brawley, California; Olga Villa, University of Notre Dame, South Bend, Indiana; Dr. Gustav Bansmer Grandview Clinic, Grandview, Washington: Joe Segor, Attorney, Migrant Services, Miami, Florida; and Miriam Guido, Attorney, Migrant Legal Action Program, Inc., Washington, D.C.

III. Legislative History

The Migrant Health Act was initially approved on September 1962 as Public Law 87–692 and became Section 310 of the Public Health Service Act. The Act enabled the Secretary of the Department of Health, Education and Welfare to make grants to public and other nonprofit agencies, institutions and organizations for paying part of the cost of: (a) establishing and operating family health service clinics for domestic agricultural workers and their families and (b) conducting special projects to improve health services and the health conditions.

In 1965, the Act was amended to include "necessary hospital care" (Public Law 89–109). The Act was then extended in 1968 (Public Law 90–547).

In 1970, the Act was again amended and extended through June 30, 1973 (Public Law 91–574). The amendments included the following changes:

(a) The population to be served was broadened to include "persons (and their families) who performed seasonal agricultural services".

(b) Consumer involvement was mandated: "persons broadly representative of all elements of the populati9n to be served" must pe given an opportunity to participate in the development of such programs, and will be given the opportunity to participate in the implementation of such programs.

(c) Restated program purpose to include "to improve and provide a continuity in health services".

(d) Allied health professions personnel were added for training purposes in establishing and operating clinic services.

These amendments served to stimulate the development of Migrant Health Program Regulations which were published in the Federal Register (May 25, 1972) with special reference to requirements for consumer participation, for the required scope of services for primary care family health clinics and for other conditions outlining the eligibility of applicants for receiving Federal funds.

IV. The Problem and Need

When the Congress of the United States first funded the Migrant Health Act in 1962, it was in recognition of the failure of existing private health services or government programs to provide adequate health care services to the nation's migrant workers.

Those who worked with the migrant laborer also knew that due to substandard living conditions, inadequate nutrition, and an inability to gain entry into any health care system, the migrant worker and his family were constantly plagued by communicable and chronic disease.

There was no mystery as to the reasons for these conditions. The average family income during the 1960's for a family of five was less than $2,500 per annum according to Department of Labor estimates. The depressed life style of migratory laborers and their families, the isolation and exploitation they faced, and the lack of social services available to them as they criss-crossed the nation from Texas to Michigan, Florida to Ohio and New York, from Arizona to California and Washington was evident.

Ten years later, in 1972, health care conditions for the migrant farm worker still remain critical. According to the Department of Health, Education, and Welfare's testimony and other submitted documents, the Migrant Health Program, largely due to inadequacies of funding levels, still reaches less than 10 percent of the eligible population.

Statistics also continue to show migrants with the worst health problems among American citizens.

Health status of migrants

A large number of studies have documented the poor health of migrants as a group. Among the findings of these studies are the following:

Migrant births occur outside of hospitals at nine times the national rate (18.1 to 2.4%).

Infant mortality for migrants is 25% higher than the national average (30.1 to 24.4 per 1,000 live births).

Mortality rates for TB and other infectious diseases among migrants are two and one-half times the national rate; for influenza and pneumonia, it is 20% greater than the national rate.

Hospitalization for accidents is 50% higher than the national rate.

The average American has seven times the numbers of medical visits per year than the average migrant (4.3 vs. .61 visits).

In 1968, $12 per capita was spent for health services for migrants; more than $250 per capita was spent nationally.

But the first ten years of the Migrant Health Act did demonstrate, that there were ways of developing health services for a migrant population. Night family health clinics were started in labor camps. Bilingual personnel were employed. In fact, it was within the Migrant Health Program that the recruitment and training of the bilingual community health worker was first started in a project in Kern County, California in 1964. Some of the migrant projects, particularly in the northern states, made impressive strides in developing one-stop comprehensive primary care service. In other states, the Migrant Health Program provided financial incentives to existing health facilities seeking to induce them to accept migrant patients.

By 1971, as a result of a Special Migrant Task Force, the Migrant Health Program had developed several prototypes of health care delivery services for various migrant populations. The three models most commonly found were based upon the size of the migrant influx: a) services for short term high concentration of migrants, such as found in Oregon, Washington, Ohio; b) services for longer term high concentration of migrants, such as found in northern Florida, parts of California, Michigan or Colorado; c) services for home base areas such as Florida, Texas, parts of California and parts of Colorado. Ironically, despite the popular notion that it would be impossible to establish anything but make-shift operations for migrants in rural areas, it was demonstrated that in less than three years, most of the projects could develop on-site laboratory capabilities, basic diagnostic services, family centered primary care rather than fragmented categorical clinics, bilingual personnel, on-site medical services and referral services to specialty practices.

However, despite the progress that was made in giving migrant workers and their families greater access to health care, four major issues still recurred frequently enough to attract legislative attention. They were: The inadequacy of the funding level; The need for earmarked hospital funds; The need to reaffirm Congressional commitment to consumer participation; and The need to develop a strategy for integrating migrant workers into a larger health care delivery system if such should develop.

The need for earmarked hospitalization funds

In 1965, the Migrant Health Act was amended to include the provision of "necessary hospital care."

However, because of the low level of total funding, it was administratively determined by DHEW that hospital care costs would not be covered by the Migrant Health Program. An attempt was to be made to use Medicaid and other Federal, State or local payment programs to try and provide hospital care. However, with the exception of the State of Michigan, which pays for migrant hospitalization through state funds, no such payment programs were identifiable.

It is now clear that this attempt has failed and that to a large extent migrants are denied access to hospital care.

A November 1969 HEW Task Force Report concluded that few states provide any medical assistance under Medicaid for migrants.

A 1971 OEO report made an almost identical finding. For example, in a detailed survey of migrants in Florida, it found 3.2 percent covered by Medicaid.

The most recent study conducted by Community Change, Inc., an HEW-funded year-long evaluation of the migrant health program also found that migrants were not covered by Medicaid or Medicare and generally were excluded from any hospital care.

The study said: "The site visits made it clear that comprehensive health services without hospital access were simply not comprehensive. Relying on 'other resources' or 'local responsibility' resulted in limited hospitalization, critical delays and numerous personal indignities . . . ."

During testimony at the hearings HEW acknowledged that less than 10 percent of the migrants nationwide are covered by any hospital care insurance.

Without exception, all witnesses, from the directors of migrant health projects, to attorneys familiar with health problems of the migrants, recognized the failure of the existing system to provide hospital care.

Witnesses including the chairman of the National Migrant Health Advisory Committee, Dr. Gustav Bansmer of Washington, recommended a separate authorization for hospital care.

The Group Health Cooperative of Puget Sound reports that its in-patient hospital care costs are approximately 30 percent of the $138 per person health care costs.

The RFK Foundation Health Plan estimates its in-patient hospital care costs are 35 percent of the total cost.

The lack of sources by which migrant hospitalization can be paid has not only been a financial nightmare; it has also caused personal indignities and callous treatment to those in need of care. According to the testimony given at the Senate Subcommittee hearing of a representative of the Lower Rio Grande Valley:

> To be admitted, the patient must pay a $150.00 deposit or sign a promissory note if he cannot show coverage under some kind of insurance plan or policy, regardless of his income or ability to pay. If the migrant worker or indigent is unable to pay his bill, the hospitals seek to collect on the promissory note. After repeated attempts have failed, the notes may be turned over to collection agencies who use whatever means available to collect.

Recently published Hill-Burton Regulations have virtually closed the possibility of migrants getting hospitalization under the "free-care" provision.

Presently, no other alternatives exist for hospitalization of migratory agricultural workers and migrant health projects have been instructed not to allocate funds to hospitalization because of the drain this will cause on their resources. The only solution is to increase funding under the Act so that the 1965 Amendment to the Act, including hospital care within the Act, will be implemented.

The need to reaffirm congressional commitment to consumer participation

In 1970 (Public Law 91–209) an amendment mandated:

> "Persons broadly representative of all elements of the population to be served" must be "given an opportunity to participate in the development * * * (and) in the implementation of such programs."

The amendment was adopted following extensive hearings by the Migratory Labor Subcommittee into the powerlessness of the migrant. In May, 1972, DHEW published a final version of the Migrant Health Regulations which had a somewhat weakened provision for consumer participation. After an inquiry from members of the Senate, representatives of DHEW stated that they would like to strengthen the language regarding consumer participation, but that the existing legislation did not justify it.

It was further stated that according to studies sponsored by DHEW, consumer-based projects did in fact demonstrate "the greatest likeli-

hood of operating a comprehensive health project which can meet the performance requirements of scale, accessibility, acceptability and efficiency."

Witnesses described the racial and cultural indignities they have traditionally faced by providers who had little sensitivity to the health needs of the migrant worker. Many witnesses also described the difficulties those from the served population had in competing for jobs in projects where sponsorship was not consumer based, even when the job applicant was qualified.

The Committee has approved additional language which provides for priority in the awarding of grants to those grantees whose policy-making boards are comprised of a majority of migrant workers and seasonal farm workers who would be served by the program. The Committee also expects that technical assistance to consumer groups in the preparation of their applications will be forthcoming from DHEW to assure their ability to compete equally with government or professional sponsors with more familiarity with the grant application and approval process.

The need to develop a strategy for integrating migrant workers into a larger health care system if such systems should appear

The witnesses before the subcommittees all expressed the long range hope that the migrant worker might at some time become integrated into a larger health care delivery system serving a broader spectrum of the society. At the same time, there was a recognition of the fact that such systems are not a reality in the rural areas at this time.

Nonetheless, in light of other health initiatives which are taking place nationally, such as currently introduced bills regarding health maintenance organizations and health service organizations, the committee felt that the time had come to authorize—where local projects so request—the use of a portion of migrant health funds for the payment of premiums for pre-paid health care if such programs provide adequate out-reach and follow-up services. The Committee felt, however, that there was no evidence that this alternative would have a major impact on migrants for the duration of this extended Act.

The inadequacy of the funding levels

According to DHEW, there are approximately 1,000,000 migrants and dependents. Also, there are approximately 3 million seasonal farm workers who are eligible for service under this act. DHEW in its testimony estimated that its budget request would reach approximately 284,000 farm workers, or less than 10 percent of the target population.

The DHEW estimate of the total cost of providing both comprehensive care and hospital services to the farm worker population eligible under the act was $600 million. Therefore, it is not surprising that in the past with levels of budget requests and appropriations as shown in the table below, it was impossible for the migrant health program to provide comprehensive care to the program recipients.

Most projects found it difficult, if not impossible, to provide the services that were considered essential to a comprehensive care facility. They also found financial restraints preventing them from providing the transportation facilities which were needed for adequate out-reach.

In some of the more temporary or short term projects where services are purchased on a visit-by-visit basis through the season, clinics have had to close before the migrants have left the area because the clinics ran out of funds. Other projects have cut corners by cutting down hours of clinic services. A visit to most of the clinics will show that funds are not used for spacious quarters or elaborate architecture. In fact, may of the projects have difficulty in meeting the "human dignity" requirement since they had no money to build adequate partitions or seating facilities for patients.

In addition, each year the program is left with a stack of "approved but unfunded projects" which are needed to serve other migrants but which cannot be funded because of inadequate appropriations. According to DHEW, there are almost 900 counties that have a seasonal migrant impact. Some 700 of the counties are not covered by the current program.

Each year, despite reports from the Department of Labor that fewer and fewer migrant and seasonal farm workers will be utilized due to mechanization, existing projects keep reporting an increased case load. Berrien County, Michigan, for example, which is one of the largest migrant impact areas, has reported at least a 25 percent increase over the previous year for each of the past three years.

According to a statement submitted by Sister Cecilia Abhold, administrator of the East Coast Migrant Health Project, 77 percent of those interviewed stated that they plan to be a part of the migrant stream next year, while only 17 percent indicated that they were in their last season. The sad fact is that migrant workers continue to seek work despite the fact that there indeed might be fewer jobs each year.

In the same statement, Sister Cecilia noted that out of 94,000 migrants covered by the East Coast Migrant Health Project, her project is only able to deal with 20,000 workers.

Finally, there are the words of one of the project directors of a migrant health project. After describing one patient who came to his clinic, he stated:

> Recently he came to the Center for a follow-up examination and he thanked those who had assisted him. Without the specific advocacy of the Center, he might well have died at an early age. His only fault being that he, like thousands of others, does not fit into any of our neat programmatic medical insurance plans, nor does he have the resources to provide for his own care. He works in a most difficult and strenuous occupation, that of picking the food for your tables. The fruits of his labor are like those of many like him; he is poor, alienated and excluded from most meaningful social legislation; for although we are willing to benefit from his misery we are not willing to accept, and readily extricate ourselves from, the responsibility of providing for his most basic needs. This may be politically, and economically expeditious; but it also appears cynical and immoral.

MIGRANT HEALTH—APPROPRIATIONS HISTORY

[In thousands of dollars]

Fiscal year	Authorized	Appropriated: Grants	Appropriated: Director operations	Appropriated: Total
1962	3,000	750	241	991
1964	3,000	1,500	496	1,996
1965	3,000	2,500	482	2,982
1966	7,000	3,000	500	3,500
1967	8,000	7,200	800	8,000
1968	9,000	7,200	811	8,011
1969	9,000	7,200	825	8,025
1970	15,000	14,000	1,000	15,000
1971	20,000	14,000	1,841	15,841
1972	25,000	17,950	1,101	19,051
1973 (estimated)	30,000			

V. Committee Views

The Committee regards this bill with the highest priority. The Committee believes it is imperative that the Migrant Health Act should be extended. The Committee regretted the absence of recommended levels for authorized funding from the Department of Health, Education and Welfare's witnesses. It does not however concur with the Department's recommendation of "not extending the migrant health authorities until we have completed our review." There have been at least four major studies of the program within the past three years. The Committee feels assured that the program has already been studied enough for the purposes of legislative guidance, and that no useful purpose would be served by postponing the enactment of S. 3762.

Further, the hearing record underlines the imperative need for the continuance of this program. The paucity of health services in rural areas and the barriers to access to existing services due to residency, language and institutional complications were stated repeatedly. According to HEW testimony during the hearings:

> Generally, the migrant population is geographically scattered and mobile. Nevertheless, it tends to be concentrated in predominately rural areas which suffer from problems of maldistribution of health resources. The lack of available resources affects not only the migrants but many of the persons who reside in rural areas. This is a very complex problem for the migrant as well as the rest of the rural population, for which no easy solution has been developed.
>
> Migrant health needs are complex and varied. In some respect migrant and seasonal farmworker health problems are a manifestation of the problems that face many rural Americans in obtaining adequate health care. In microcosm, migrants have problems with financing, with availability of resources and accessibility to care. In addition, cultural and language barriers make obtaining adequate services difficult for the migrants. The mobility of a migrant population further complicates the problem and makes the provision of comprehensive health care with continuity a very difficult one indeed.

Finally, Dr. Gustav Bansmer, Chairman of the National Migrant Health Advisory Committee testified:

> I can state with equivocation that (the migrant health program) is appropriate, that it is necessary for a large, underserved major economic need of this country—the migrant, agricultural laborer is a vital necessity to the well-being of agriculture. It is completely obvious that mechanization is reducing hand labor, but agriculture will still require large volumes of labor, large volumes of agricultural technicians and mechanics.
>
> Until such time as this nation develops a national system or systems of health care delivery which will permit each individual to have access to comprehensive health care or until such time as the nation eliminates those arrangements which require separate health care delivery mechanisms for various ethnic or income groups, it is encumbent on the government of the United States to give more attention, more support to the health care needs of the migrant farm worker.
>
> We must still recognize that this approach to the health care of the migrant farm worker is not the last and best answer to this problem—it is a temporary answer—but a necessary answer at this time.

The basic issue before the Committee therefore in the extension and increase of authorization evolved around an acceptable level of increased authorization. The approved compromise was reached on the level of funding and accepted unanimously.

In full agreement that the migrant and seasonal farm worker should be given access to a improved health care systems as they evolve, the Committee unanimously agreed with Section 2, which permits funds to be used for the payment of premiums for a prepaid health care plan eligible for federal assistance when such clinics, special projects so request. It also added that all such clinics, special projects, and prepaid health care plans shall provide out-reach and follow-up services.

The Committee gave strong endorsement to a separate authorization and need for paying for hospital care. There was no disagreement on the part of the Committee that hospitalization needs of migrants were not being met. Documentations presented by witnesses that other sources of payment, including Medicaid and Medicare, were not available to pay the hospitalization costs of migrant workers and their families. Therefore, the Committee approved a separate authorization to cover the costs of hospital care.

The Committee also cautioned that hospitalization should not be determined by ability to pay but rather by need. The Committee felt that hospitalization guidelines should be established by HEW so that hospitalization will not be used inappropriately in lieu of primary care or outpatient services. Hospitalization should also be paid for by this grant only as an extension of comprehensive health care delivery system, and not as an isolated inappropriate alternative to care.

The Committee requested a report on effects of this new authorization before the next extension of the Migrant Health Act. In light of the residency requirements which are often the greatest barriers to migrants getting hospital care, the Committee places a priority of

utilizing these funds for those migrants, who by virtue of their residency cannot qualify for other third party payment. The Committee was further persuaded to so amend the Act in light of the most recent Hill-Burton regulations, which for all practical purposes makes the "free care" provision virtually inaccessible to migrants.

By amending the Act to include subsection (c), the Committee provided that "In making grants under the section, the Secretary shall give priority to those applicants whose policy-making body is composed of a majority of persons who are consumers of its services, where competing applicants appear to the Secretary of Health, Education and Welfare to be equally qualified."

This amendment re-stated Congressional intent regarding the consumer participation amendment passed in 1970 (P.L. 91-209). In addition, the Committee heard impressive and persuasive testimony that consumer-based projects, better than any other model of migrant health project, showed the potential for better accountability to consumers; more comprehensive scope of services; better outreach and follow-up services; a higher percentage of persons from the same culture being recruited and trained for higher level jobs within the project; and better methods of cost accounting. This was documented by at least two studies sponsored by HEW, and by testimony of witnesses themselves.

Equally significant, the Department of Health, Education and Welfare representatives stated in a meeting with staff representatives of the Senate that they would like to strengthen the consumer participation aspect of the legislation, but found it impossible to do so in light of the ambiguous wording within the current Act. The Committee therefore agreed upon an amendment to the Act.

Although the amendment gives clear indication of Congressional intent that preference will be given to applicants whose policy boards are composed of a majority of persons who are consumers of service, that in the absence of such groups (which might be the case in certain rural areas) other prototypes of sponsorship can be funded.

Finally, in keeping with its strong commitment to the principle that consumers should have a majority representation on the policy-making board of migrant projects providing such services, the Committee encourages the Secretary to provide any technical assistance required to establish and maintain programs whose policy-making board is composed of a majority of consumers.

VI. Tabulation of Votes Cast in Committee

Pursuant to section 133(b) of the Legislative Reorganization Act of 1946, as amended, the following is a tabulation of votes in Committee:

Motion to report the bill to Senate carried 17-0.

Voting Aye: Sens. Williams, Randolph, Pell, Kennedy, Nelson, Mondale, Eagleton, Cranston, Hughes, Stevenson, Javits, Dominick, Schweiker, Packwood, Taft, Beall and Stafford.

VII.—COST ESTIMATES PURSUANT TO SEC. 252 OF THE LEGISLATIVE REORGANIZATION ACT

[In millions]

	1973	1974	1975
Comprehensive primary care	$30	$105	$120
Hospitalization	20	35	40
Grand total	50	140	160

SECTION-BY-SECTION ANALYSIS

S. 3762—A BILL TO EXTEND THE PROGRAM FOR DOMESTIC MIGRANT AND SEASONAL AGRICULTURAL WORKERS

Section 1

Amends section 310 of the Public Health Service Act to reauthorize and extend (through fiscal year 1975) the program of grants for health services for domestic migrant and seasonal form workers and their families. Increases fiscal year 1973 authorization for such program by $30 million.

There are authorized t be appropriated for such grants: $60 million for fiscal year 1973; $105 million for fiscal year 1974; and $120 million for fiscal year 1975.

Section 2

Amends section 310 of the Public Health Service Act to authorize the Secretary to make grants to meet the costs of premiums for prepaid health care plans where local grantees request such grants. Requires such grantees to be eligible for federal assistance. Requires clinics, special projects, and prepaid health are plans, receiving assistance under section 310, to provide outreach and follow-up health services.

Section 3

Amends section 310 of the Public Health Service Act by adding new subsection 310(b).

New subsection 310(b) authorizes the Secretary (fiscal year 1973 through fiscal year 1975) to provide funds to assist in the provision of necessary hospital ore to domestic agricultural migrants and their families.

There are authorized to be appropriated for such purposes: $20 million for fiscal year 1973; $35 million for fiscal year 1974; and $40 million for fiscal year 1975.

Section 4

Amends section 310 of the Public Health Service Act gy adding new subsection 310(c). New subsection 310(c) requires the Secretary, when making any grants under this section, to give priority to those grant applicants whose policymaking body is composed of a majority of persons who use its services. Such priority is to be given when applicants competing for grants under section 310 appear to the Secretary of HEW to be equally qualified.

CHANGES IN EXISTING LAW

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

PUBLIC HEALTH SERVICE ACT, AS AMENDED

* * * * * * * *

TITLE III—GENERAL POWERS AND DUTIES OF PUBLIC HEALTH SERVICE

* * * * * * * *

HEALTH SERVICES FOR DOMESTIC AGRICULTURAL MIGRANTS

SEC. 310. (*a*) There are hereby authorized to be appropriated not to exceed $7,000,000 for the fiscal year ending June 30, 1966, $8,000,000 for the fiscal year ending June 30, 1967, $9,000,000 each for the fiscal year ending June 30, 1968, and the next fiscal year, $15,000,000 for the fiscal year ending June 30, 1970, $20,000,000 for the fiscal year ending June 30, 1971, $25,000,000 for the fiscal year ending June 30, 1972, and [$30,000,000 for the fiscal year ending June 30, 1973,] *not to exceed $60,000,000 for the fiscal year ending June 30, 1973, $105,000,000 for the fiscal year ending June 30, 1974, and $120,000,000 for the fiscal year ending June 30, 1975* to enable the Secretary (1) to make grants to public and other nonprofit agencies, institutions, and organizations for paying part of the cost of (i) establishing and operating family health service clinics for domestic agricultural migratory workers and their families, including training persons (including allied health professional personnel) to provide services in the establishing and operating of such clinics, (ii) special projects to improve and provide a continuity in health services for and to improve the health conditions of domestic agricultural migratory workers and their families, including necessary hospital care, and including training persons (including allied health professions personnel) to provide health services for or otherwise improve the health conditions of such migratory workers and their families *and (iii) premiums for a prepaid health care plan eligible for Federal assistance where such clinics or special projects so request. All such clinics, special projects, and prepaid health care plans shall provide out-reach and follow-up services;* and (2) to encourage and cooperate in programs for the purpose of improving health services for or otherwise improving the health conditions of domestic agricultural migratory workers and their families. The Secretary may also use funds appropriated under this section to provide health services to persons (and their families) who perform seasonal agricultural services

similar to the services performed by domestic agricultural migratory workers if the Secretary finds that the provision of health services under this sentence will contribute to the improvement of the health conditions of such migratory workers and their families. For the purposes of assessing and meeting domestic migratory agricultural workers' health needs, developing necessary resources, and involving local citizens in the development and implementation of health care programs authorized by this section, the Secretary must be satisfied, upon the basis of evidence supplied by each applicant, that persons broadly representative of all elements of the population to be served and others in the community knowledgeable about such needs have been given an opportunity to participate in the development of such programs, and will be given an opportunity to participate in the implementation of such programs.

(b) There are hereby authorized to be appropriated $25,000,000 for fiscal year ending June 30, 1973, $35,000,000 for the fiscal year ending June 30, 1974, and $40,000,000 for the fiscal year ending June 30, 1975 to enable the Secretary to assist in the provision of necessary hospital care to domestic agricultural migratory workers and their families.

(c) In making grants under this section the Secretary shall give priority to those applicants whose policymaking body is composed of a majority of persons who are consumers of its services, where competing applicants appear to the Secretary of Health, Education, and Welfare to be equally qualified.

APPENDIX B

(Excerpts from Part 8A, "Migrant and Seasonal Farmworker Powerlessness," July 20, 1970, Hearing before the Subcommittee on Migratory Labor of the Senate Committee on Labor and Public Welfare)

MIGRANT AND SEASONAL FARMWORKER POWERLESSNESS

(Who Is Responsible?)

MONDAY, JULY 20, 1970

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

The subcommittee met at 9:30 a.m., pursuant to call, in room 318, Old Senate Office Building, Senator Walter F. Mondale (chairman of the subcommittee) presiding.

Present: Senators Mondale (presiding), Yarborough, and Saxbe.

Committee staff members present: Boren Chertkov, counsel.

Senator MONDALE. The subcommittee will come to order.

This morning the Migratory Labor Subcommittee begins the eighth in a series of hearings on "Migrant and Seasonal Farmworker Powerlessness."

Today, we begin hearings with the conscience of a Nation awakened to our cause. Last week's remarkable NBC–TV documentary "Migrants—An NBC White Paper," has created an atmosphere of outrage and revulsion over the desperate plight of hundreds of thousands of our fellow citizens who have systematically been denied the status, the rights, the pride, the human decency, and the reward for their labor which we hold to be the birthright of all Americans.

We saw the documented evidence of the squallor, degradation, and racism which our Nation bestows upon the migrants. We saw the helplessness, fear, and frustration of a people whose only hope is for their children to escape the fate into which they were born. And we saw, most tragically, these children—underfed, poorly clothed, deprived and isolated—falling further behind in school and falling further into the hopeless trap of the migrant stream.

A migrant camp is a microcosm of nearly every social ill, every injustice, and everything shameful in our society: poverty almost beyond belief, rampant disease and malnutrition, racism, filth and squalor, pitiful children drained of pride and hope, exploitation and powerlessness, and the inability or unwillingness of public and private institutions, at all levels, to erase this terrible blight on our country.

This is not the first time that the shame of America has come to us in prime time. Ten years ago, a similarly remarkable documentary called "Harvest of Shame" was nationally televised; and still an-

124 blank

other, "What Harvest for the Reaper," has been produced since then.

Perhaps our greatest shame is how little we have done in this decade. We know the problems. In this subcommittee alone, we have had seven series of hearings—on the life of the migrant as described by the farmworker himself, the reasons for the successes and failures of union and community organization efforts, the border commuter problem, legal problems, the effects of pesticides on the farmworker, the economic and manpower issues.

We must now turn to the question of why we have accomplished so little.

What are the powers, the pressures, the politics, and the special interests that have perpetuated this degradation? Who has opposed the investigations of these conditions, and who has endeavored to suppress the truth? And who has worked to oppose the legislation or frustrate the administration of programs which might at least begin to meet the problems that are now so well documented?

This morning, we begin with a panel of doctors, Dr. Raymond Wheeler, Charlotte, N.C.; Dr. Harry Lipscomb, Houston, Tex.; Dr. Ramiro Casso, McAllen, Tex,; and Dr. Gordon Harper, Boston, Mass., who comprised part of a team of distinguished doctors who dealt with the health problems of migrants and their families.

We begin with Dr. Wheeler.

STATEMENT OF RAYMOND M. WHEELER, M.D., INTERNIST, CHARLOTTE, N.C.

Dr. WHEELER. Thank you, Senator Mondale.

Before I begin, I would like to introduce to the committee my medical colleagues who are with me today.

On my left is Dr. Harry Lipscomb of Houston.

On my immediate right, Dr. Ramiro Casso, McAllen, Tex.; and Dr. Gordon Harper of Boston.

I am a physician engaged in the private practice of internal medicine in Charlotte, N.C.

I am a member of the American Medical Association, a Fellow of the American College of Physicians, and am certified as a specialist in internal medicine by the American Board of Internal Medicine.

I am also president of the Southern Regional Council, an organization of black and white southerners, who for 25 years have sought and worked for equal opportunity for all citizens of the southern region.

During the past 3 years, I have studied the health and living conditions of the poor in North Carolina, Mississippi, Alabama, Florida, southwest Texas, Appalachia, and in the ghettos of northern cities.

I have examined children, talked to their parents, and visited their homes and schools.

I have served as a member of the Citizens' Board of Inquiry into Hunger in the United States, which published the report entitled "Hunger, U.S.A."

I have testified before committees of both the House and Senate of the United States concerning the existence of hunger and malnutrition throughout this country.

In January and again in April of this year, I traveled with other medical colleagues in southern Florida observing the health and living conditions of migrant farmworkers. In March of this year, my colleagues here today and I visited Hidalgo County in southwest Texas. We were part of a medical team of about 25 physicians, medical students, and technicians. There we spent 5 days examining farmworkers and their families, talking with them and other members of the community, and visiting homes and labor camps in which the people live.

Beginning with our visits to Mississippi and Alabama in 1967 and including our trips to Florida and southwest Texas this year, the efforts of all the physicians involved in this work have been sponsored and encouraged by the Field Foundation.

The purpose of our studies and our reports have always been the same. We have sought to observe and study the life situations of children of the poor, in order to bring their conditions to national attention. Their condition is one of sickness and poverty, isolation and neglect, indifference and exploitation, resulting in tens of thousands of children who exist in our country today without hope, denied their basic rights as human beings, and condemned to lives of pain, frustrations, and despair. In our minds, there can be no question about this fact.

It seems equally certain that this tragic situation is directly related to another. In our affluent, money-oriented society, human needs of children have been subordinated to political and economic interests.

Senator MONDALE. Would you yield there, Doctor?

I think that is a point that is often ignored. We like to say of ourselves that we are a child-oriented society. We hear about that all the time. But I have heard from many others like you who have dealt with the problems of the disadvantaged in American society, and they have all come up with the same conclusion you have—that really we show very little concern, if any, for the children of the poor.

They are, of course, the most tragic victims of all. They have no way of fighting back. They have no way of obtaining their own food, or their own housing, or in other ways taking care of themselves. They have no way to demand a quality education. As a result, we mangle and destroy thousands of them, millions of them, in a very cruel way.

If we were truly a child-oriented society, that would have stopped decades ago.

Dr. WHEELER. I certainly agree, Senator.

It would not be consistent with our beliefs or our purpose to portray those interests as intrinsically evil. Rather, we see them as basically uninformed, insensitive, and uncaring about the vast and irreparable harm that is being done not only to children, but to the very fabric of a society in which these children must live and take their places as adult citizens.

Wherever we went, in the south, the southwest, Florida, or Appalachia, the impact was the same—varying only in degree or in gruesome detail.

We saw countless families with large numbers of children, isolated from the mainstream of American culture and opportunity, possessing none of the protections of life and job and health which other Americans take for granted as rights of citizenship.

If the farmworker is injured in the field or if he becomes ill from exposure to pesticides—we heard of and saw many instances of both situations—he does not receive workmen's compensation. If he is sick or cannot find work—and there are many days when work is not available—he does not receive unemployment insurance. There is no realistic minimum wage to guarantee him adequate pay for his work.

If social security payments are deducted from his wages, few records are kept by the crew boss on which he can later base a claim.

He has no health or hospital insurance to provide him with even minimal medical care and he does not earn enough to purchase it.

The farmer is not even prohibited from working young children in the fields if the parents, desperate for enough money to buy food and shelter, chose to take their children out of school or bring along their pre-school-age children to pick the vegetables.

We saw housing and living conditions horrible and dehumanizing to the point of our disbelief. In Florida and in Texas, we visited housing projects, built with public funds, which defy description.

We saw living quarters constructed as long cinder block or wooden sheds, divided into single rooms by walls which do not reach to the ceilings. Without heat, adequate light or ventilation, and containing no plumbing or refrigeration, each room—no larger than 8 by 14 feet—is the living space of an entire family, appropriately suggesting slave quarters of earlier days. I doubt if the owners of fine racing horses or dogs along the east Florida coast would think of housing their animal property in such miserable circumstances.

We saw many different kinds of housing and perhaps some of the worst from the standpoint of structural soundness—owned by those who lived there—did not create in me the feeling of outrage that some of the so-called better housing did.

For example, in Dade County, we looked at quarters operated by the Homestead Housing Authority with public funds. There someone had sat down at a drawing board and deliberately and callously designed a living unit which consisted of a single room with concrete block walls, divided partially by a block partition which jutted out in the center of the room. There was one door and one small window high up under the ceiling. The room was dark and damp at midday. There was nothing in that unit to make it habitable.

There was not one gesture toward providing either comfort or basic human needs—no source of water, no toilet, no refrigeration, no heat, and the lighting was so dim that no child could have possibly been able to read or study.

This was the creation of a public authority, a place in which it was willing for other human beings to live.

Senator MONDALE. How old was that housing unit?

Dr. WHEELER. It was fairly old. As I recall, perhaps 30 years.

Senator MONDALE. I noted on my visits that a lot of these so-called housing units were built in the mid-1930's. The Farm Security Administration was responsible for some of that construction. They are, as you have described them, unbelievable places for human beings to live. Yet, for those 30 or 35 years they have been making money off that housing. They still charge very high rents.

There is very little upkeep, and practically no effort to make them

habitable. Not only are these units miserable, but, in addition, the local governments are making money on them. It is the only place that the migrants have to live. They are being charged very high prices.

Dr. WHEELER. As I recall, one of the mothers that we talked with who lived in one of the places I just described told me she paid $14 or $15 a week.

Senator MONDALE. That sounds like a standard charge. And, nothing goes to the tenant, under these circumstances, except very bad housing.

I got the impression that the last time this Nation was concerned about migrants was in the middle 1930's. I remember one farmworker who told that their housing was built after Eleanor Roosevelt visited. They built some nice housing. They would like to have another liberal visit and get some more housing.

You see this all over the country: California, Texas, Florida. The last time there was any substantial migrant housing built, as rotten as it is, was probably in the middle 1930's.

Have you noticed that?

Dr. WHEELER. We saw very little in the way of new housing.

I recall in this particular Homestead, Fla., development they were building a few on the periphery of the camp. There was very little new housing in evidence at the places I visited.

Senator MONDALE. The only place I saw new housing was outside of Delano because the tenants struck because they were living in small corrugated shacks that were built after Mrs. Roosevelt visited 30 years ago. A grown man could not stand up in them. You can imagine what that is like in the summer, two little holes in each side, what they call windows, I guess.

These families were cramped in there. They were paying fantastic rents. They finally had a rent strike, and the county then built some new housing.

Senator YARBOROUGH. Dr. Wheeler, Senator Mondale, the chairman of this subcommittee, and I visited a number of Colonias in Cameron and Hidalgo County in the past few months. Back of that screen of briar and thornbush out in front is a kind of thornbush curtain that can be 100 yards from the highway and the traveling public on the major U.S. highway traveling for years never dreamed that those Colonias existed.

When we went in there, we were told we were the first legislators who had ever been in there from either a congressional or a State legislative committee.

We found the conditions of sanitation and ill health—not being doctors, we could not judge the ill health except from seeing them and talking to the people and having them tell us about it but we could see conditions of sanitation and the other things there that you are describing.

I was not with Senator Mondale in Florida. But these we saw in my home State when we went there. We inquired about the health programs we enacted. We found not even a registered nurse came into those Colonias to look at the people.

So, you have people listening who have seen some of these things

with their own eyes. We listen with great interest and a great hope of doing something about it.

Dr. WHEELER. I share that hope.

Senator MONDALE. Please proceed, Dr. Wheeler.

Dr. WHEELER. I think while we are talking about housing it would be helpful for us to think about the effects on a child who has to live in one of these poorly ventilated, poorly lighted one-room dwelling units, aside from the physical health, the physical discomfort of the heat, the cold, and dampness.

The absence of fresh air and the crowding greatly increases the likelihood of transmission of contagious disease. This is why so many have tuberculosis as well as chronic respiratory infections.

How is it possible for a child to study and perform in school when it is impossible for him to read by the light available to him? How can he possibly be emotionally well adjusted when he has no privacy, when he lives in a cage? How can he possibly stay awake in school the following day when he has attempted to sleep in a bed with three or four of his brothers and sisters?

How can this be, in a society such as ours, with the values we are presumed to cherish?

In all of the areas we visited, the nearly total lack of even minimally adequate medical care and health services was an early and easily documented observation. Again, that which most Americans now agree to be a right of citizenship, was unavailable to most of the people whom we saw.

The standard procedure of requiring cash for services and a cash deposit before hospital admission, places an impossible burden upon those least able to afford the high cost of being sick. Documentation of discrimination in medical services and denial of medical care will be described during the course of the hearings.

We saw hundreds of people whose only hope of obtaining medical care was to become an emergency which could not be turned away. We heard countless stories of driving 50 or 100 miles to a city general hospital after refusal of care at a local hospital.

Mexican-American citizens of the United States told us of crossing the border into Mexico for dental and medical treatment which was less expensive and for care which was considered to be kinder, more humane than they could obtain in their own communities.

We heard of diagnoses and treatment by nurses, endless waiting for simple procedures such as immunization of small children, and degrading treatment by medical personnel.

A few statistics substantiate our observations. The migrant has a life expectancy 20 years less than the average American. His infant and maternal mortality is 125 per cent higher than the national average. The death rate from influenza and pneumonia is 200 percent higher than the national rate and from tuberculosis, 250-percent higher than the national rate. The accident rate among migrant farmworkers is 300 percent of the national rate.

We know from these statistics alone that the migrant and seasonal farmworkers live shorter lives, have more illnesses and accidents, lose more babies, and suffer more than the rest of us. Everything that we saw and heard in Florida and southwest Texas bore out this knowledge.

From the moment we set foot in Hidalgo County until we departed, our medical team was engulfed by a seemingly endless procession of distraught and anxious parents, bringing their elderly relatives and their families of six, eight, or 10 children—seeking medical treatment which they could not obtain in their own communities.

Senator MONDALE. Doctor, can you tell us, just briefly, how this medical team proceeded? Was there a public announcement that medical examinations would be made available and then in response to this the migrants and their families arrived? How were the people told of your availability?

Dr. WHEELER. I think Dr. Casso might be able to answer that since he was there before the team arrived and is perhaps more familiar with the exact mechanism of how the information was disseminated than I.

Dr. CASSO. I am not familiar with just how people were advised that this was going to happen. But there will be other witnesses later on, perhaps Mr. Fernandez and Mr. Dunwell, who perhaps will be more knowledgeable than I about that.

Senator MONDALE. Dr. Casso, didn't you testify before the Health Subcommittee at McAllen?

Dr. CASSO. I testified at the Edinburg, Tex., hearings, yes.

Senator MONDALE. Proceed.

Dr. WHEELER. In partial answer to your question, some of the community leaders in the Colonias knew we were coming and told their people about it. After we got there, the word spread very rapidly. There was some television coverage over the local station and the radio and in the newspapers. It seemed to be adequate in view of the number of people who turned out.

Senator MONDALE. Could you make an estimate of how many people you saw and treated?

Dr. WHEELER. I believe we saw about 1,400.

Senator MONDALE. Did you give them treatment as well as examinations?

Dr. WHEELER. We tried to treat some of the sickest people. We had very little in the way of facilities for treatment and for follow-up care. But we were able to give some care and make prompt referrals of some of the sickest people we saw.

Senator MONDALE. How many doctors were on the team?

Dr. WHEELER. There were 15 doctors.

Senator MONDALE. Proceed.

Dr. WHEELER. I was describing this mass of people who confronted us when we arrived there. I want to comment just a little about these people.

Most of these people live constantly at the brink of medical disaster, hoping that the symptoms they have or the pain they feel will prove transient or can somehow be survived, for they know that no help is available to them. Only two groups have any hope for relief: Those who are somewhat better off financially and those who are most critically ill and become emergencies.

Some of the people we saw were not seriously ill, or perhaps not ill at all, but none of them know, and most had never had the opportunity to find out, if they were healthy or whether tomorrow might bring disaster.

Our group was not equipped to offer very much in the way of definitive treatment for the vast amount of illness we saw. Perhaps the most constructive and most helpful acts that we performed involved the opportunities to assure some, who had never seen a physician before, that they were, indeed, well and could continue their struggle to survive without the nagging fear of physical disability or death.

For the rest, the majority of the hundreds of people we examined, it was a different, frustrating, and heartbreaking story. We saw people with most of the dreadful disorders that weaken, disable, and torture, particularly the poor.

High blood pressure, diabetes, urinary tract infections, anemia, tuberculosis, gallbladder and intestinal disorders, eye and skin diseases were frequent findings among the adults.

Almost without exception, intestinal parasites were found in the stool specimens examined. Most of the children had chronic skin infections. Chronically infected draining ears with resulting partial deafness occurred in an amazing number of the smaller children. We saw rickets, a disorder thought to be nearly abolished in this country, and every form of vitamin deficiency known to us that could be identified by clinical examination was reported.

Senator MONDALE. What do you call that disease of the ears?

Dr. WHEELER. Chronic otitis media.

Senator MONDALE. There seems to be an almost unvarying correlation between poverty and otitis media. We have seen this in Eskimos and Indian children. Apparently it is very widespread with migrant children.

Dr. WHEELER. This is an easily preventable disease. Treatment with antibiotics can prevent or cure most of the ear infections that we saw.

Senator MONDALE. But, unattended, it is not only terribly painful but it can destroy the child's capacity to hear for purposes of education, and a normal life, can it not?

Dr. WHEELER. That is correct.

Senator MONDALE. Perhaps many of these children who think they are subnormal for other reasons are really suffering from a hearing defect as a result of this otitis media. Is that the answer?

Dr. WHEELER. That is part of the answer.

Senator YARBOROUGH. Among the skin disorders, Doctor, did you see any leprosy?

Dr. WHEELER. I believe we saw one case of leprosy.

Dr. Lipscomb will give you a detailed rundown of the number of diseases and the different kinds that we saw.

There was one case of leprosy.

I doubt that any group of physicians in the past 30 years has seen, in this country, as many malnourished children assembled in one place as we saw in Hidalgo County.

There is one place I remember particularly—a labor camp in Weslaco, a small town east of McAllen.

As we walked between the rows of dwelling units, many small children played around us, running about barefooted through mud and pools of stagnant, refuse-filled water—the perfect culture for intestinal parasites, polio, and bacteria-causing infectious diarrhea which kills so many children.

We stopped and examined children at random and almost every child had some preventable physical defect. We saw tiny youngsters drinking rice water out of bottles because their mothers had no milk to give them. Chronic skin infections, both fungage and bacterial, were practically a "normal" finding.

Rickets is supposed to be a rather rare disease these days but we saw one child after another with deformed ribs and legs, thickened wrists, which are the classical landmarks of the disease. One youngster, standing apathetically near a group of playing children, had all the stigmata of advanced protein deficiency—sparse, thin, reddish hair; thin, drawn face; protuberant abdomen; and thin, wasted extremities.

We stepped into one single-room dwelling unit where parents and six children lived. Amazingly, it was spotlessly clean in spite of the fact that the nearest source of water was a block away.

On the bed lay a 3-month-old infant who weighed less than the average newborn. It was emaciated, restless, wailing, and occasionally pulling at a bottle which we soon discovered contained sour milk. There was no refrigerator in which to keep formula. The child had been ill for weeks, according to its mother, but at its last visit to the clinic, a day or two earlier, no medication had been prescribed. A very quick examination disclosed pus pouring from its right ear. We made arrangements for the child to have penicillin and individually packaged feedings of formula which the mother could not afford. I suspect we were too late, and I doubt if the child survived.

What I have just attempted to describe in Weslaco is documented on film taken by Martin Carr of NBC. When the decision was made to confine the documentary on the migrant to Florida, that film was not used and remains in the possession of NBC. It is my hope that it will be preserved and made available to the Nation, for it portrays conditions which cannot be adequately described by mere words.

Senator MONDALE. The NBC documentary was originally intended to include some of the work you were doing in Texas; is that correct?

Dr. WHEELER. That is possibly why the television filming team was there.

Senator MONDALE. But the final documentary used only film that was taken in Florida?

Dr. WHEELER. That is right.

Senator MONDALE. So that the film they shot in Texas was not seen?

Dr. WHEELER. That is right.

Senator MONDALE. I think it might be a good idea for this subcommittee to ask NBC if they could make that film available to us so that we might look at it. I think we should. I deeply regret that it hasn't been made available for general public viewing, though perhaps there were technical and production problems, or most likely, there just was not the time to show all the horrors.

Dr. WHEELER. Because of the tremendous numbers of people who sought our help in a limited time, we interviewed and examined entire families as a unit. In one tiny rural settlement, with a medical student assisting me, I spent an entire day examining one family after another. It was a shattering experience.

Their dietary histories were all the same—beans, rice, tortillas, and little else. The younger children, especially, were undersized, thin,

anemic, and apathetic. The muscles of their arms were the size of lead pencils—a sign of gross protein malnutrition. Many had evidence of multiple vitamin deficiencies and almost without exception, their skins were rough, dry, inelastic, with the characteristic appearance of vitamin A deficiency.

I remember vividly the shock I received when one young boy was brought in who was well-nourished and I touched his skin—warm, soft, resilient—unlike any I had seen all day, and I called to the student with me to come and put his hand on that child in order that he might refresh his memory of what a healthy skin feels like.

The children we saw that day have no future in our society. Malnutrition since birth has already impaired them physically, mentally, and emotionally. They do not have the capacity to engage in the sustained physical or mental effort which is necessary to succeed in school, learn a trade, or assume the full responsibilities of citizenship in a complex society such as ours.

In 1967, my medical colleagues and I traveled through the Mississippi Delta and rural Alabama. There, we saw hunger and poverty and human misery to a degree that we had not dreamed possible in affluent America.

In 1970, 2½ years later, we have found in Florida and Texas, rich and fertile States, other forgotten Americans, living and working in near slavery, their children living and dying in conditions as dreadful as any we had previously encountered.

Senator MONDALE. Would it be fair to say that, despite two and a half years of national debate and discussion, despite national television documentaries that were shown depicting this unspeakable human tragedy, that for all practical purposes the lives of those you visited and saw just a few weeks ago were unimproved. And, that there was no improvement at all over what you had seen just two and a half years ago?

Dr. WHEELER. I regret very much I have to agree with you.

Senator MONDALE. The one objection I had to the NBC documentary was the comment that so much had happened, that there was so much improvement in the past years. Maybe there are places where there have been improvements. But I have been in many migrant camps, and I have talked to many a farmworker. If there has been any improvement, you need a better set of eyes than I have, and in spite of the improvement which does exist there still is such unutterable human degradation and poverty, that it is not worth commenting on.

Would you agree with that?

Dr. WHEELER. Yes, sir; without any hesitation at all.

Senator YARBOROUGH. Mr. Chairman, I think that is a sad commentary on the enforcement of Federal laws. Under the previous chairman of this subcommittee, Senator Harrison Williams, we enacted the first migrant labor health laws. The Congress appropriated millions of dollars to see that something was done.

In our visit down there last year, we found a doctor, a retired Army medical doctor, in charge, and just a few people, one registered nurse, for a vast area. But about all they were doing was keeping records. They were not giving treatment to the people or examining patients.

They were drawing salaries, but from what we could see very little was being done with the money we appropriated.

Senator MONDALE. I can remember going in the slums and the migrant health director saying, "Gosh, it is interesting."

I said, what do you mean "it is interesting?"

He said, "These people living like pigs down there."

He had never been there before. It was his job; he was supposed to be in charge of their health. Yet, he had not even been there.

Senator YARBOROUGH. The reason the Army doctor took it is because they could not get a medical doctor to do it. He just sat at the county seat and drew a salary and had responsibility over about four counties.

Doctor, there is one thing you said in here, in this row of one-room installations, putting a whole family in one room, 8 by 14 feet. You said it suggested slave quarters of earlier days.

I have been around on tours and looked at some of these old slave quarters on plantations. Most of those I ever saw had a separate cabin for each slave family. At least, the ones I have seen that still survive. The slave quarters had more space than this for the slaves.

Have you seen that type where they had a separate cabin?

Dr. WHEELER. Yes; I have pictures of them.

Senator YARBOROUGH. They had more space than some of these migrant workers have now.

Senator MONDALE. That is the difference between owning and renting slaves. The owner had to take care of them; he had an equity in them.

Senator YARBOROUGH. He had a great investment in them.

Senator MONDALE. That is right.

Dr. WHEELER. It is not likely that we saw more malnutrition or more human misery than we had seen in the Delta. Perhaps, in the time that we were there, we did not experience as much overt hostility expressed by the white community as we had sensed in Mississippi and Alabama.

In the Delta, mechanization of the huge farm industries had rendered thousands of people useless to the economy, and they were left to die or to survive as best they could. In some instances, it seemed clear that there was an unspoken conspiracy to solve the problem by making life so intolerable that people were forced to flee the land and the State in which they could no longer earn a living. No longer needed and unable to secure help from the white community, the black Mississippian at least had the freedom to leave, if he were able, and to seek a better life elsewhere.

In Florida and Texas, the farm worker remains a valuable asset to the owners and operators of the huge farms which produce food and fruit for the Nation. Without them, corn and tomatoes would rot in the fields, and oranges and grapefruit would shrivel on the trees. There is no way that these farms can be operated without the migrant work force which moves about the area, harvesting the beans and squash this week, moving on to gather the avocadoes another week, in another county. Mechanization has not yet devised a way to replace them.

What is different in Florida and Texas from the rest of the rural South is the deliberate, cruelly contrived, and highly effective system which has been devised to extract the maximum work and productivity from other human beings for the cheapest possible price.

Every effort is directed toward isolating the farmworker from the rest of society, maintaining him at the lowest level of subsistence which he will tolerate—then making certain that he has no means of escape from a system that holds him in virtual peonage. And, to that the grower has the full cooperation of the Federal Government, the State, and the local community.

Senator YARBOROUGH. Doctor, let me say a word there.

You know in 1966, through the Labor and Public Welfare Committee, we brought the minimum wage law for the first time in this Nation to farmworkers.

Now, Franklin D. Roosevelt had a national minimum wage law in 1933 to protect the workers in the factories and in the fields. But, for a long period of time, people who advocated such laws were never able to pass the laws through the Congress to protect the workers in the fields. We were able to pass that law in 1966 and brought the minimum up to $1 the first year, $1.15, $1.30 an hour. It is a minimum, not a maximum. A very poor wage but a minimum wage, where before the wages paid had been about half that.

I noted earlier in your statement something which indicated that the problem was that there has been no enforcement of that law and failure to enforce it or failure to get the benefits of it to the worker. I think this committee ought to explore that, whether the law we have passed has been implemented.

Here the Congress has shown some concern by passing laws to put money into States to educate the migrant workers and put a minimum wage on their labor. Over the course of the past 10 years, these laws have been passed. The problem is, as we go out to the "colonias," as those settlements are called, that the English-speaking people seldom see them, and many of the more affluent Mexican-Americans never see them.

The problem has been to get these laws to the people to make them operative, but the Federal Government has in the past 10 years been working, and trying to do something.

Senator MONDALE. It is my impression that minimum wage laws are are being widely avoided and violated. And, the employer has to be fairly large in the first place.

Senator YARBOROUGH. Seven or more workers. All the big farms have more than that; the farms in Hidalgo County who hire 100 at a time.

Dr. WHEELER. One way to go around it is by so-called piece rates for piecework. They pay the worker on the basis of his production. They pay by the pound or by the bushel or by the basketload for what he picks.

Working on a piecework basis and being paid that way, it is my understanding that very few of these workers are able to earn what would amount to the full minimum wage for the number of hours worked.

At this point in my report, in order that what I say next will not be misinterpreted, I would like to express my high regard and respect for the members of the Subcommittee on Migratory Labor and my admiration for the hard work, the commitment, and the efforts of all of you in your attempt to better the life of the migrant. No one has done more.

At the same time, I have questions which I feel must be raised or I will not have carried out my responsibility to you or to the people about whom we are both concerned.

These questions relate to the reasons for this hearing and the many hearings which have preceded it on the same and related subjects.

You are perhaps even more aware than I of the volumes of information and the days of testimony which are already available to you and to the Congress, documenting the fact of children in our midst who are stunted physically, dulled mentally, and warped emotionally—children who are deprived of all opportunity to become productive citizens—children who will grow up to become wards of society or worse—perhaps hostile, alienated, and destructive.

I have here a copy of a report of the President' Commission on Migratory Labor, written and submitted to President Truman in 1951. Even a cursory examination of its pages will reveal that the plight of the migrant has not changed significantly during the intervening 19 years.

What does it take to make us care about our children?

The picture we saw is one of a society thriving on greed, cruelty, alienation, and fear—a society which either never had or has completely abandoned the concerns, the ethics, the ideals which make dignity and freedom possible.

What has been done to convince the Congress of the United States, the most powerful group of men in the world, that the time has come to put aside its greed, its prejudice, its concern for personal power and prestige—and to be concerned for the kind of society in which our children must live together?

You, and only you, can change all this. How is it possible to justify the endless words and the devious political maneuvers which have delayed and withheld meaningful aid to children who don't have enough to eat, children whose parents have no jobs and no money for food or medical care?

How can the Congress and our Nation's leadership pretend to be related in any sane way to the world around them when they spend their time and the Nation's wealth building roads and guns and planes and elaborate government buildings while families live 10 or 12 in one room without water, heat, ventilation, or even a place to wash their hands?

And children die—even worse, most of them live, numbed by hunger and sickness, motivated only by an instinct for survival, crowded into the ghettos of horror which abound in our country which produce desperation and loss of faith in our system. Our answer seems to be more police, more guns, and more punitive laws whenever they protest.

We came away from Florida and Texas with tremendous admiration for the leaders of the people we met. These men, often at great risk, were working to give their people hope and leadership which would dispel their apathy and despair.

In many respects, these people were stronger than most of us. They endure what seemed to me to be the unendurable, with patience, humor, and understanding. Remarkable in view of the misery which surrounds them and the powerlessness they experience. They have not given up the hope that we, who can help, will someday raise our voices and

say that there are some things in our country which are intolerable, that these things can be changed, and must be changed. Our time is running out.

Thank you, Mr. Chairman.

[Applause.]

Senator MONDALE. Thank you, Dr. Wheeler, for a most moving and historic statement of the current tragedy and disgrace of the lives of the migrants and their families.

You make a challenge, a challenge to us, in your conclusion that I can't answer.

We have spent days and years in this committee listening to the evidence of human tragedy, tragedy that should never occur anywhere in the world, let alone in the wealthiest society on earth. We pass laws that provide only minimal coverage and minimal benefits, but even they seem to be ignored. Bills pass the committee or the Senate and never become law.

For example, a year and a half ago we traveled to a Nutrition and Human Needs Committee hearing in Collier County and elsewhere. It was readily apparent that the only kind of food program that would work is one in which the Federal Government had the ultimate responsibility for finding the hungry and feeding the poor. If we depended on the local power structure, you could be absolutely certain that the poor were not even going to be identified, let alone going to receive food assistance.

I led the fight in the Senate to help overcome that problem. We passed an amendment which includes that Federal responsibility in the so-called McGovern-Javits bill. But that bill has languished in the House Agriculture Committee since that time. I regret that the administration is not supporting us in that record. But without that responsibility, I don't think we are going to meet the needs of these human beings. It just won't happen.

After we came back from our hearings in McAllen, Tex., I was so outraged that we tacked an amendment on the Migrant Health Act requiring the establishment of advisory boards composed of the target population so that the migrants and their families would have to be consulted in migrant health programs.

Now, I do not know for sure, but I have been told that not a single such council has been established. It is just as though there is little difference between passing a law and sending a letter, our legislation is just sort of advisory these days. It is something that the administration will think about and do, or not do, depending on what they want to do.

The other day I led the fight for unemployment compensation for the migrants, at least coverage for those working for the very largest farmers. We have passed that in the Senate. It was not in the House bill. It was the first thing dropped in the Conference Committee. Even the Washington Post, which I regard as one of the most liberal decent journals of our country, wrote a public editorial saying, let us not jeopardize our program by fighting over the migrants. Let us drop that thing and go on to fight another day.

If there is anything expendable, if there is any human being that has been relegated to the status of worthless trash in the U.S. society, it is the migrant. Yet, they work harder than practically any other

working man in our society. They crawl on their bellies, they stoop, they climb, all over this land just trying to find enough to live on.

I accept the challenge; I accept the criticism; but the truth of it is that the migrant is without a friend powerful enough to make any substantial difference in his life, and that has been true for 50 years.

* * * * * * *

Senator MONDALE. Senator Saxbe, do you have any questions?

Senator SAXBE. Thank you, Mr. Chairman.

Doctor, as you know, we are interested not only in the migrant problem but in the general health problem, in this committee. We have had quite a bit of testimony as to how we can get medical care to people even if these people are not migrants. If the are poor, they still need medical attention which they are not getting.

The Surgeon General and others have testified before us that at the present time the doctors just aren't available to staff the kind of outpatient clinics that are necessary or to do the fieldwork that is necessary.

Do you have any suggestions on how better delivery of medical care might be accomplished in your State or in the Southwest?

Dr. WHEELER. Senator Saxbe, the problem of the adequate delivery of medical care to all the people of our country is an extremely complex one, as you know. There is no simple solution that I can think of. It involves adequacy of numbers of medical and paramedical personnel; it involves more efficient means of delivery of care or greater use of that technology in bringing that care to the people.

One of the things that it involves most of all at this point, at least in a nation which has no national health insurance program, is the sufficiency of doctors for people to be able to buy medical care. If they can't get it, of course, they can't buy it.

Senator SAXBE. This is what we hear from the AMA but I just question this. If you have 200,000 physicians with 175,000 of them practicing, all working and working hard, and most of them are—if you just put more money into the thing, does that help?

Now, this, it seems to me, has been the kind of thinking which has brought us to the present place. Everybody says we will put more money into the program. You put more money in the program but you don't make more doctors.

Dr. WHEELER. No; you are correct. We certainly at this point do not have enough doctors in this country the way they are presently being utilized. As a matter of fact, I am certain that we could do a much better job of delivering medical care to the people of this country if the services of doctors were utilized in a much more effective way. There are many, many doctors in the country today who could help in this problem if their services were being more adequately utilized.

Senator SAXBE. Do you think the Federal Government is going to have to go to the doctor and say, "Look, you are wasting your time; you are not providing service; we will tell you how to spend your time."

Do you think that is what it is going to come to?

Dr. WHEELER. I hope not. I hope there is enough concern about this problem and interest and enough willingness to exert leadership on the part of physicians, not only on the national level in our associations, but also in our communities, that with the increasing pressures to do something about these problems the medical profession will assume its responsibility and participate with lay people at all levels on the planning of how to get medical care to people.

Senator SAXBE. One of the problems we face is the increasing pressure of the various colleges of surgeons and internists and so on to increase the qualifications. Recently, I believe this year, it was proposed that they add another year to surgical residence.

I have a son in surgical residence. He has been there 3 years. He has 2 more to go; and 2 years in the Army. He will be 33 years old before he hits a clinic.

It seems to me that we have to do something to get people at the local level to run a clinic. Now, they all want to go to the medical center and have offices next door to each other and pass people around. But I feel

very strongly that we have to have 3-year general practitioners. We are doing this at Ohio State this year. We are starting a 3-year program and no internship. They spend 3 years in medicine and they go out. They are not going to be able to do brain surgery and things like that but they can certainly take care of the complaints and detect things that can be referred.

Now, can this be an answer?

Dr. WHEELER. This is one of the things I am talking about when I talk about the effective utilization of medical personnel. The length of time it takes to train a doctor is unnecessarily long, in my opinion—that is just one thing—and the failure to train and to utilize a large number of paramedical personnel who can do a great many things that doctors now have to do.

I think the fee-for-service system in itself has built into it all sorts of inefficiencies that make for poor medical care. I think there need to be many more prepaid plans, and there should be a countrywide program of national health insurance to extend to everyone the benefits that medicare and medicaid are now attempting to extend.

We are a little bit off the subject of my responsibility.

Senator SAXBE. We are, and we are not. The three of us, I know, see eye to eye because we supported this outpatient clinic amendment to the Hill-Burton Act. But if outpatient clinics were available at these migrant camps, even if you had to put them on trucks and haul them around—obviously the people you saw had not seen a doctor for a long time or had any medical treatment.

Your testimony indicates, and this is what we hear constantly, chronic cases where children are dying from illnesses that obviously reflect no medical attention at all.

If we can get more mobile facilities that move from camp to camp and at least have a sick call once a week, we would go a long way toward curing some of the things you referred to here; could we not?

Dr. WHEELER. It would help a great deal.

Of course, along with that there has to be also a very vigorous attack on sanitation, on housing, on water supplies, on sewage disposal, garbage pickup; all these things. Otherwise, you are simply putting a bandaid on a horrible wound.

Senator SAXBE. This is generally resisted at the camp level.

Dr. WHEELER. Resisted by who?

Senator SAXBE. By the camp owners.

Dr. WHEELER. Yes, sir. Very little cooperation. They make no effort in that direction at all, none.

Senator SAXBE. That is all I have.

Senator MONDALE. Senator Yarborough.

Senator YARBOROUGH. Doctor, I have followed your statement with great interest and, despite the failure of the executive departments to implement the laws of Congress, I want to tell you that this is one committee of Congress that is concerned over this problem, has been for at least 10 years, the Labor and Public Welfare Committee.

In mentioning hunger as being the basis of this, let me point out that the first hunger hearings that I recall started with this committee in 1967 and the leaders were Senator Robert Kennedy and Senator Joe Clark, of Pennsylvania. They went into the Delta, they went into California and said the people were starving; there was hunger. There

was an assault on this committee generally by the press of America by saying there is no hunger, there is slander, politically motivated. They wrote editorials in paper after paper, including my own State.

After a year of investigations, many of those same papers changed and the editorials said there is hunger in America, there is malnutrition in America, and we have to do something about it.

A survey was made of my State. Nearly all the people on the team were from Texas so that they would not be open to a charge that they brought in outsiders. They had made a similar survey in Guatemala. They had found conditions of hunger in areas of Texas very similar to the areas in Guatemala.

The efforts of this committee ran jurisdictionally into the opposition of the Agriculture Committee of the Senate. So, to keep that problem of conflict from stymieing the work, it was agreed that a Special Select Committee on Malnutrition and Hunger would be established. The Senator from South Dakota is chairman of that committee. I am a member of that committee as a representative of the Labor Committee.

We continued work and we put in more money; we added an amendment on the floor of $500 million for that, additional money, for the school lunch program.

But the tragic thing about it is, as you have pointed out in all the testimony before that committee, we asked the question, How much would it cost to end hunger in America? That question was asked of Secretary of Agriculture Freeman in January of last year just before he left office. Acting with his staff and knowledgeable people, he said a billion dollars. That was the lowest estimate we had.

The highest estimate—and the only people we asked were the people who know the prices of food and deal with distribution—was $3 billion. The highest estimate we had from anyone to end the hunger in America was $3 billion a year. They have been spending $3 billion a month in South Vietnam for years.

We saw news media, that used to sweep this under the rug, say we spent $110 billion on the war in South Vietnam. The debilitating cost of that war is pulling down American society. It did not cause hunger in America; we have had it all these generations, but it has held down the money.

People decry the expenditures, say you are spenders, spenders. The strange thing is when we spend money on food they call us spendthrifts. They never call spendthrift anybody who votes for the squandering of that money in Southeast Asia. From the national resource standpoint alone, and the health and strength of this Nation, it is folly. It is absolute folly.

You put your finger on that. In one of the paragraphs of your prepared statement, among other things you mention, "How can the Congress and our Nation's leadership pretend to be related in any sane way to the world around them when they spend all of their money, and that is the big drain, in Southeast Asia.

I think when we put up the money to build the tiger cages and go and inspect them and know they are there, we are just as responsible for the tiger cages as any petty dictator in South Vietnam. We gave them the money and we sent our supervisors around there to see them.

I assure you there are concerned people. We are intelligent enough to know the cost. Those of us who have been working on that, a number of us, Robert Kennedy was assassinated; 2 years before that Paul Douglas was defeated in Illinois; 2 years ago, Wayne Morse on this committee and Joe Clark on this committee, two of the most active men in this field, were defeated. I was defeated May 2.

Now, we all have intelligence enough to know when you try to do something for the poor you run a great risk of not coming back. But the encouraging thing is that each time one of us is liquidated politically or otherwise, there is another man waiting. You see him here in Mondale of Minnesota, Kennedy of Massachusetts, Cranston of California, Hughes of Iowa, Eagleton of Missouri on the full committee. There are more standing ready to take their places.

So, I think the movement for justice in this field is going to grow. I don't think the fact that a number of us get politically liquidated is going to stop the movement for justice in America for food and medical care.

Senator Saxbe has put his finger on one thing, the avarice that has kept America from educating enough doctors. Let us face it. We have had such a monopoly that we could not get enough medical schools. We have 160 doctors per 100,000 population. Soviet Russia has 280 doctors per 100,000 population. They are educating just as fast as they can, increasing their medical schools to get 360 doctors per 100,000 population. They have found that is the size of a medical corps that it will take to care for the health of the people. For each doctor, they have a medical assistant that we are beginning to provide for in our law. Something like a halfway doctor, you might say, not a physician or surgeon but the medical assistant, one for each medical doctor in Russia.

We, being the richest and most affluent Nation that the world has ever seen, cannot remain down where we are in health for the people. We can no longer remain 21st among the nations of the world in the average longevity of a male child.

A male child born in America, as you know, being a doctor, has an average shorter life than a male child born in 20 other nations on earth. Our infant mortality rate puts us down about 14th among the nations of the world. This is a shame, it is a thing that must be alleviated.

I have been on this health subcommittee for 12 years, and have supported every measure to improve the health of our citizens, like the one to build 20 new medical schools and dental colleges under the Hill-Burton Act. I floor-managed the action recently in which we overrode the Presidential veto on putting a mere two and three-quarter billion dollars more for 5 years to build hospitals and outpatient clinics. We know that is a token based on the needs but that is all we could pass.

I want to say that this committee is concerned and has been working on this for years. We pass laws in the Senate but by the time they get through the conference with the House they are always less.

We had a $6 billion hospital bill we passed out of this committee and it passed the Senate, $6 billion for 5 years. When we finished with the House in a conference, we were lucky to get out with two and three-quarter billion dollars.

So, what is needed is something to strike the conscience of the Nation. We need a reorientation of national priorities so that the health and education of the people become foremost objectives of this Government, not bragging about what the kill ratio is in South Vietnam, not bragging about how many tons of bombs we drop. We dropped month after month a greater weight of bombs on North Vietnam than were ever dumped on Germany and Japan together in World War II.

The thing we ought to brag about and put in headlines on the front page is how much hunger we have alleviated in this country, how much disease we have cured, not how many people we have killed. We have to turn from a death-oriented society to a health-oriented society and improve the health care for the people in this country.

Yours is one of the most powerful statements I have seen in 12 years on the health subcommittee.

Thank you for the contribution you are making to alleviate the conditions of life in these United States.

Dr. WHEELER. Thank you, sir.

Senator MONDALE. Dr. Wheeler, we have interrupted your fine statement on several occasions, so I order it printed in its entirety at this point in the hearing record.

(The prepared statement of Dr. Wheeler follows:)

PREPARED STATEMENT OF RAYMOND M. WHEELER, M.D., CHARLOTTE, N.C.

My name is Raymond M. Wheeler. I am a physician engaged in the private practice of Internal Medicine in Charlotte, N.C. I am a member of the American Medical Association, a Fellow of the American College of Physicians, and am certified as a specialist in Internal Medicine by the American Board of Internal Medicine. I am also President of the Southern Regional Council, an organization of black and white Southerners, who for twenty-five years have sought and worked for equal opportunity for all citizens of our region.

During the past three years I have studied the health and living conditions of the poor in North Carolina, Mississippi, Alabama, Florida, Southwest Texas, Appalachia, and in the ghettoes of Northern cities. I have examined children, talked to their parents, and visited their homes and schools. I have served as a member of the Citizens' Board of Inquiry into Hunger in the United States which published the report entitled *Hunger, U.S.A.* I have testified before committees of both the House and Senate of the United States concerning the existence of hunger and malnutrition throughout this country.

In January and again in April of this year I traveled with other medical colleagues in Southern Florida observing the health and living conditions of migrant farm workers. In March of this year, my colleagues here today and I visited Hidalgo county in Southwest Texas. We were part of a medical team of about twenty-five physicians, medical students and technicians. There we spent five days examining farmworkers and their families, talking with them and other members of the community, and visiting homes and labor camps in which the people live.

Beginning with our visits to Mississippi and Alabama in 1967 and including our trips to Florida and Southwest Texas this year, the efforts of all the physicians involved in this work have been sponsored and encouraged by the Field Foundation. The purpose of our studies and our reports have always been the same. We have sought to observe and study the life situations of children of the poor, in order to bring their condition to national attention. Their condition is one of sickness and poverty, isolation and neglect, indifference and exploitation, resulting in tens of thousands of children who exist in our country today without hope, denied their basic rights as human beings, and condemned to lives of pain, frustrations, and despair. In our minds there can be no question about this fact. It seems equally certain that this tragic situation is directly related to another. In our affluent, money-oriented society, human needs of children have been subordinated to political and economic interests.

It would not be consistent with our beliefs or our purpose to portray those interest as intrinsically evil. Rather, we see them as basically uninformed, insensitive, and uncaring about the vast and irreparable harm that is being done not only to children, but to the very fabric of a society in which these children must live and take their places as adult citizens.

Wherever we went, in the South, the Southwest, Florida, or Appalachia the impact was the same—varying only in degree or in gruesome detail.

We saw countless families with large numbers of children, isolated from the mainstream of American culture and opportunity, possessing none of the protections of life and job and health which other Americans take for granted as rights of citizenship.

If the farmworker is injured in the field or if he becomes ill from exposure to pesticides (we heard of and saw many instances of both situations), he does not receive Workman's Compensation. If he is sick or cannot find work (and there are many days when work is not available) he does not receive unemployment insurance. There is no realistic minimum wage to guarantee him adequate pay for his work. If Social Security payments are deducted from his wages, few records are kept by the crew boss on which he can later base a claim. He has no health or hospital insurance to provide him with minimal medical care and he does not earn enough to purchase it. The farmer is not even prohibited from working young children in the fields if the parents, desperate for enough money to buy food and shelter, choose to take their children out of school or bring along their pre-school age children to pick the vegetables.

We saw housing and living conditions horrible and dehumanizing to the point of our disbelief. In Florida and in Texas, we visited housing projects, built with public funds, which defy description. We saw living quarters constructed as long cinder-block or wooden sheds, divided into single rooms by walls which do not reach to the ceilings. Without heat, adequate light or ventilation, and containing no plumbing or refrigeration, each room (no larger than 8x14 feet) is the living space of an entire family appropriately suggesting slave quarters of earlier days. I doubt if the owners of fine racing horses or dogs along the East Florida coast would think of housing their animal property in such miserable circumstances.

We saw many different kinds of housing and perhaps some of the worst from the standpoint of structural soundness (owned by those who lived there) did not create in me the feeling of outrage that some of the "better" housing did. For example in Dade County we looked at quarters operated by the Homestead Housing Authority with public funds. There someone had sat down at a drawing board and deliberately and callously designed a living unit which consisted of a single room with concrete block walls, divided partially by a block-partition which jutted out in the center of the room. There was one door and one small window high up under the ceiling. The room was dark and damp at mid-day. There was nothing in that unit to make it habitable. There was not one gesture toward providing either comfort or basic human needs—no source of water, no toilet, no refrigeration, no heat, and the lighting was so dim that no child could have possibly been able to read or study. This was the creation of a public authority, a place in which it was willing for other human beings to live.

Can you imagine the effects on a child of living in such a situation—the physical discomfort of the heat, the cold, the dampness? The absence of fresh air and the crowding greatly increases the likelihood of transmission of contagious disease. This is why so many have tuberculosis as well as chronic respiratory infections. How is it possible for a child to study and perform in school when it is impossible for him to read by the light available to him? How can he possibly be emotionally well-adjusted when he has no privacy—when he lives in a cage? How can he possibly stay awake in school the following day when he has attempted to sleep in a bed with three or four of his brothers and sisters?

How can this be, in a society such as ours, with the values we are presumed to cherish?

In all of the areas we visited, the nearly total lack of even minimally adequate medical care and health services was an early and easily documented observation. Again, that which most Americans now agree to be a right of citizenship, was unavailable to most of the people whom we saw. The standard procedure of requiring cash for services and a cash deposit before hospital admission, places an impossible burden upon those least able to afford the high cost of being sick.

Documentation of discrimination in medical services and denial of medical care will be described during the course of the hearings.

We saw hundreds of people whose only hope of obtaining medical care was to become an emergency which could not be turned away. We heard countless stories of driving 50 or 100 miles to a city general hospital after refusal of care at a local hospital. Mexican-American citizens of the U.S. told us of crossing the border into Mexico for dental and medical treatment which was less expensive and for care which was kinder, more humane than they could obtain in their own communities. We heard of diagnoses and treatment by nurses, endless waiting for simple procedures such as immunization of small children, and degrading treatment by medical personnel.

A few statistics substantiate our observations. The migrant has a life expectancy twenty years less than the average American. His infant and maternal mortality is 125% higher than the national average. The death rate from influenza and pneumonia is 200% higher than the national rate and from tuberculosis, 250% higher than the national rate. The accident rate among migrant farmworkers is 300% of the national rate.

We know from these statistics alone that the migrant and seasonal farmworkers live shorter lives, have more illnesses and accidents, lose more babies, and suffer more than the rest of us. Everything that we saw and heard in Florida and Southwest Texas bore out this knowledge.

From the moment we set foot in Hidalgo County until we departed, our medical team was engulfed by a seemingly endless procession of distraught and anxious parents, bringing their elderly relatives and their families of six, eight, or ten children—seeking medical treatment which they could not obtain in their own communities. Most of these people live constantly at the brink of medical disaster, hoping that the symptoms they have or the pain they feel will prove transient or can somehow be survived, for they know that no help is available to them. Only two groups have any hope for relief: Those who are somewhat better off financially and those who are most critically ill. Some of the people we saw were not seriously ill, or perhaps not ill at all, but none of them knew, and most had never had the opportunity to find out, if they were healthy or whether tomorrow might bring disaster. Our group was not equipped to offer very much in the way of definitive treatment for the vast amount of illness we saw. Perhaps the most constructive and most helpful acts that we performed involved the opportunities to assure some, who had never seen a physician before, that they were, indeed, well and could continue their struggle to survive without the nagging fear of physical disability or death.

For the rest, the majority of the hundreds of people we examined, it was a different, frustrating, and heartbreaking story. We saw people with most of the dreadful disorders that weaken, disable, and torture, particularly, the poor.

High blood pressure, diabetes, urinary tract infections, anemia, tuberculosis, gallbladder and intestinal disorders, eye and skin diseases were frequent finding among the adults.

Almost without exception, intestinal parasites were found in the stool specimens examined. Most of the children had chronic skin infections. Chronically infected draining ears with resulting partial deafness occurred in an amazing number of the smaller children. We saw rickets, a disorder thought to be nearly abolished in this country, and every form of vitamin deficiency known to us that could be identified by clinical examination was reported.

I doubt that any group of physicians in the past thirty years has seen, in this country, as many malnourished children assembled in one place as we saw in Hidalgo County.

There is one place I remember particularly—a labor camp in Weslaco, a small town East of McAllen.

As we walked between the rows of dwelling units, many small children played around us, running about barefooted through mud and pools of stagnant, refuse-filled water—the perfect culture medium for intestinal parasites, polio, and bacteria causing infectious diarrhea which kills so many children.

We stopped and examined children at random and almost every child had some preventable physical defect. We saw tiny youngsters drinking rice water out of bottles because their mothers had no milk to give them. Chronic skin infections, both fungae and bacterial, were practically a 'normal' finding. Rickets is supposed to be a rather rare disease these days but we saw one child after another with deformed ribs and legs, thickened wrists which are the classical landmarks of the disease. One youngster, standing apathetically

near a group of playing children, had all the stigmata of advanced protein deficiency—sparce, thin, reddish hair, thin drawn face, protuberant abdomen, and thin, wasted extremities.

We stepped into one single-room dwelling unit where lived parents and six children. Amazingly, it was spotlessly clean in spite of the fact that the nearest source of water was a block away.

On the bed lay a 3-month-old infant, who weighed less than the average newborn. It was emaciated, restless, wailing, and occasionally pulling at a bottle which we soon discovered contained sour milk. There was no refrigerator in which to keep formula. The child had been ill for weeks, according to its mother but at its last visit to the clinic, a day or two earlier, no medication had been prescribed. A very quick examination disclosed pus pouring from its right ear. We made arrangements for the child to have penicillin and individually packaged feedings of formula which the mother could not afford. I suspect we were too late and I doubt if the child survived.

What I have just attempted to describe in Weslaco is documented on film taken by Martin Carr of NBC. When the decision was made to confine the documentary on the migrant to Florida, that film was not used and remains in the possession of NBC. It is my hope that it will be preserved and made available to the nation, for it portrays conditions which cannot be adequately described by mere words.

Because of the tremendous numbers of people who sought our help in a limited time, we interviewed and examined entire families as a unit. In one tiny rural settlement, with a medical student assisting me, I spent an entire day examining one family after another. It was a shattering experience.

Their dietary histories were all the same—beans, rice, tortillas, and little else. The younger children, especially, were undersized, thin, anemic, and apathetic. The muscles of their arms were the size of lead pencils—a sign of gross protein malnutrition. Many had evidence of multiple vitamin deficiencies and almost without exception, their skins were rough, dry, inelastic with the characteristic appearance of Vitamin A deficiency. I remember vividly the shock I received when one young boy was brough in who was well nourished and I touched his skin—warm, soft, resilient—unlike any I had seen all day and I called to the student with me to come and put his hand on that child in order that he might refresh his memory of what a healthy skin feels like.

The children we saw that day have no future in our society. Malnutrition since birth has already impaired them physically, mentally, and emotionally. They do not have the capacity to engage in the sustained physical or mental effort which is necessary to succeed in school, learn a trade, or assume the full responsibilities of citizenship in a complex society such as ours.

In 1967, my medical colleagues and I traveled through the Mississippi Delta and rural Alabama. There, we saw hunger and poverty and human misery to a degree that we had not dreamed possible in affluent America. In 1970, two and one-half years later, we have found in Florida and Texas, rich and fertile states, other forgotten Americans, living and working in near slavery, their children living and dying in conditions as dreadful as any we had previously encountered.

It is not likely that we saw more malnutrition or more human misery than we had seen in the Delta. Perhaps, in the time that we were there, we did not experience as much overt hostility expressed by the white community as we had sensed in Mississippi and Alabama.

In the Delta, mechanization of the huge farm industries had rendered thousands of people useless to the economy, and they were left to die or to survive as best they could. In some instances, it seemed clear that there was an unspoken conspiracy to solve the problem by making life so intolerable that people were forced to flee the land and the state in which they could no longer earn a living. No longer needed and unable to secure help from the white community, the black Mississippian at least had the freedom to leave, if he were able, and to seek a better life elsewhere.

In Florida and Texas, the farm worker remains a valuable asset to the owners and operators of the huge farms which produce food and fruit for the nation. Without them, corn and tomatoes would rot in the fields and oranges and grapefruit would shrivel on the trees. There is no way that these farms can be

operated without the migrant work force which moves about the area, harvesting the beans and squash this week, moving on to gather the avocadoes another week, in another county. Mechanization has not yet devised a way to replace them.

What is different in Florida and Texas from the rest of the rural South is the deliberate, cruelly contrived, and highly effective system which has been devised to extract the maximum work and productivity from other human beings for the cheapest possible price. Every effort is directed toward isolating the farmworker from the rest of society, maintaining him at the lowest level of subsistence which he will tolerate—then making certain that he has no means of escape from a system that holds him in virtual peonage. And to that end, the grower has the full cooperation of the Federal government, the state, and the local community.

At this point in my report, in order that what I say next will not be misinterpreted, I would like to express my high regard and respect for the members of the Subcommittee on Migratory Labor and my admiration for the hard work, the commitment, and the efforts of all of you in your attempt to better the life of the migrant. No one has done more.

At the same time, I have questions which I feel must be raised or I will not have carried out my responsibility to you or to the people about whom we are both concerned. These questions relate to the reasons for this hearing and the many hearings which have preceded it on the same and related subjects. You are perhaps even more aware than I of the volumes of information and the days of testimony which are already available to you and to the Congress, documenting the fact of children in our midst who are stunted physically, dulled mentally, and warped emotionally—children who are deprived of all opportunity to become productive citizens—children who will grow up to become wards of society or worse—perhaps hostile, alienated, and destructive.

I have here a copy of a report of the President's Commission on Migratory Labor, written and submitted to President Truman in 1951. Even a cursory examination of its pages will reveal that the plight of the migrant has not changed significantly during the intervening nineteen years.

What does it take to make us care about our children? The picture we saw is one of a society thriving on greed, cruelty, alienation, and fear—a society which either never had or has completely abandoned the concerns, the ethics, the ideals which make dignity and freedom possible.

What has to be done to convince the Congress of the United States, the most powerful group of men in the world, that the time has come to put aside its greed, its prejudice, its concern for personal power and prestige—and to be concerned for the kind of society in which our children must live together?

You, and only you, can change all this. How is it possible to justify the endless words and the devious political maneuvers which have delayed and withheld meaningful aid to children who don't have enough to eat, children whose parents have no jobs and no money for food or medical care? How can the Congress and our nation's leadership pretend to be related in any sane way to the world around them when they spend their time and the nation's wealth building roads and guns and planes and elaborate governmental buildings while families live 10 or 12 in one room without water, heat, ventilation or even a place to wash their hands?

And children die—even worse—most of them live, numbed by hunger and sickness, motivated only by an instinct for survival, crowded into the ghettoes of horror which abound in our country which produce desperation and loss of faith in our system. Our answer seems to be more police, more guns, and more punitive laws whenever they protest.

We came away from Florida and Texas with tremendous admiration for the leaders of the people we met. These men, often at great risk, working to give their people hope and leadership which would dispel their apathy and despair. In many respects these people were stronger than most of us. They endure what seemed to me to be the unendurable, with patience, humor, and understanding. Remarkable in view of the misery which surrounds them and the powerlessness they experience. They have not given up the hope that we, who can help, will someday raise our voices and say that there are some things in our country which are intolerable, that these things can be changed, and must be changed. Our time is running out.

* * * * * * *

PREPARED STATEMENT OF HARRY S. LIPSCOMB, M.D., DIRECTOR OF THE INSTITUTE FOR HEALTH SERVICES RESEARCH, BAYLOR COLLEGE OF MEDICINE, HOUSTON, TEX.

Senator Mondale, distinguished members of the Subcommittee, I am Harry S. Lipscomb, M.D. I am Director of the Institute for Health Services Research, Baylor College of Medicine, Houston, Texas, and member of the Citizens Board of Inquiry into Health Care Services.

You have requested that we tell you of the findings of a group of physicians who recently surveyed the health conditions of migrant and seasonal farmworkers in South Texas.

I do so with reluctance, because I am ashamed, as an American, of what we saw, and concerned, as a physician, that my colleagues and I have failed to act as leaders in the face of demonstrated need, to structure the delivery of our services so as to reach every man, woman, and child in our Nation. Dr. Wheeler has given a broad overview of what our team saw in Texas and Florida. I will now document our findings in the Rio Grande Valley.

From March 3rd through March 8th of this year, our health team examined patients in clinics and "barrios" of Hidalgo and Starr Counties, Texas. Histories and physical examinations were performed on 1400 individuals, the majority of whom were Mexican-Americans living in and around the city of McAllen, Texas. Our health team, which consisted of fifteen physicians, ten medical stu-

dents, four technicians, and two nurses, saw patients from early morning until midnight for four consecutive days. On a limited number, we performed blood counts, urinalyses, chest X-rays, pelvic examinations, and stool cultures. Additionally, we collected drinking water from 8 "barrios" for bacteriological examination.

It had been our intention to examine 50 families in great depth, but were confronted on March 4th by over 900 people lining the streets around the small clinic in which we worked. We had intended to document, but not treat illness. Within the first hour it became clear that the people had come for treatment, and their manifest need was so overwhelming that we hastily arranged with a neighboring pharmacy to provide medications and vitamins. In four days we prescribed and administered in excess of $6,000 worth of drugs, which were subsequently paid for by the Field Foundation.

The region which we chose was selected in part because of an expressed need of the community and because of an earlier well-documented nutritional study, in the same region, reported to the Select Committee on Nutrition and Human Needs of the U.S. Senate (90th Cong., 2nd Sess., and 91st Cong., First Sess.: "Nutrition and Human Needs," part 3, the National Nutrition Survey, pp. 880–922).

Two years later, 15 months after the inauguration of the Surplus Commodities program, one year after the passage of the Migratory Health Act, little has changed. Disease and malnutrition and human suffering continue. This in the face of over $6 million in farm subsidies, significant civic improvements, new highways and roads, and new hospital construction assisted by Hill-Burton funding.

In short, the Mexican-American is still a disenfranchised person.

This report will simply describe what we were able to document from our clinical impressions, X-rays, and other supporting laboratory data. It would be impossible to identify a specific cause for many of the conditions: We will describe a child with a cleft palate which has not been surgically repaired, a patient who needs glasses and has not gotten them, a mother with cervical infection who has not been treated, or a person who has not had adequate dental care, which all constitute documentable evidence of disease. On the other hand, that these conditions have occurred, or have not been remedied may be ascribed to ignorance, to lack of awareness, to lack of availability of services, or to economic barriers which cannot be identified, in all cases, with certainty. We simply cannot link disease to the reason for the disease except in a few isolated instances. We would like to say that all the malnutrition which we saw was due to an inadequate commodity program in Hidalgo County, or that poor dental care was due to a limited number of dentists and the high initial cost for care, but I do not believe that a survey of this sort can be so used. For every case of health hardship we saw involving lack of physicians or inadequate funds or improper food, we saw a balance of patients who, for sociocultural reasons or lack of educated health "awareness," *failed to seek* care. Perhaps in the culture of poverty, failure to seek reflects the hopelessness of poverty, the apathetic despair of a culture which has done without for so long that even the aspiration for care is lost. This very apathy and despair which has characterized every poor community I have visited is, unfortunately, used as evidence that the poor will not avail themselves of our services if they are provided. I believe the overwhelming turnout of the people of the Valley to our accessible clinic gives the lie to this popular misconception. These people are *hungry* for care. They are dying for want of it.

In analyzing the results of our study, we have been able to classify the conditions which we saw into the following categories.

1. Infectious disease:
   a. bacterial
   b. viral
   c. spirochaetal
   d. fungal
   e. parasitic
2. Toxic disorders
3. Metabolic disease
4. Nutritional disease
5. Neoplastic disease:
   a. benign
   b. malignant

6. Traumatic injury
7. Congenital disease
8. Degenerative disease
9. Dental disease
10. Speech, hearing, and vision defects
11. Mental, emotional, developmental and learning disorders

1. INFECTIOUS DISEASE

The *bacterial* infections which we observed included otitis media, bronchitis, laryngotracheobronchitis in children, conjunctivitis, uveitis, acute and chronic follicular tonsillitis, pyelonephritis, cervicitis, urethritis, and impetigo. Associated inflammatory conditions, perhaps of non-bacterial origin, included cholecystitis, gastritis, and esophagitis. In regard to hygiene, we found nursing mothers with mastitis, and on two occasions we examined bottles of milk for infants, which were contaminated and the milk soured. *Viral* diseases were common and many children and entire families were suffering from upper respiratory infections. A number of communicable childhood diseases were seen including rubella. It is of some significance that shortly after we left, an epidemic of poliomylitis occured in the Valley resulting in three deaths. This is the only poliomyelitis reported in the United States in 1970. If it is reasoned that the open border into Mexico is an open seeding source, then our very protection lies in immunization. In this population we have failed to provide this protection. A number of patients were reported to have syphilis and this was confirmed by serology. Fungous infections were common, particularly monilial vaginitis, stomatitis, and tinea corporis. Chest X-rays revealed the presence in at least three individuals of healed histoplasmosis, and at least two cases of previously undetected active pulmonary tuberculosis were discovered. Sarcoidosis, a disease of uncertain etiology, has been linked to some of the respiratory fungal diseases. *Intestinal parasites* were the rule. We personally saw under the microscope pin worms, hook worms, round worms, and amoeba, often occurring in combination in a single patient, and invariably occurring in several members of the same family, when present in one. Of the eight drinking-water sources which we cultured, six were contaminated with fecal organisms. (See picture in text showing two old oil barrels serving as water reservoir for four families—23 people.) Cramped living quarters combined with contaminated drinking water virtually assure the spread of any communicable or parasitic disease.

2. TOXIC DISORDERS

We have reason to suspect that a certain percentage of the migrant workers were exposed to toxic materials, notably pesticides used in the agricultural industry. Acute pesticide poisoning is easily diagnosed. We saw no evidence for this. On the other hand, many patients gave us a history of having been sprayed or been in fields shortly after a rain at which time they suffered numbness and tingling of hands and feet, and many described a seasonal skin rash associated with the use of pesticides, notably organophosphorus compounds and chlorinated hydrocarbons.

3. METABOLIC DISEASES

Metabolic disease in this population included diabetes/mellitis which occurs in high incidence in the Mexican-American. We feel that the examination of urine alone, while relatively unsatisfactory as a diagnostic procedure, uncovered 14 patients with previously undetected glycosuria. These patients must now be studied with glucose tolerance tests to confirm the presence of diabetes. Thyroid disease was common, and several cases of thyrotoxicosis were observed and at least two cases of hyxedema (thyroid deficiency) were seen. We were impressed with the palpably enlarged thyroid glands. The McGanity report had earlier emphasized the presence of endemic goiter in this population, and this we confirmed by clinical examination. It is not absolutely certain that the genesis for this is iodine deficiency alone. The possibility exists that this population may have a diet that is itself goiterogenic.

4. NUTRITIONAL DISEASE

Nutritional disease was common and consisted primarily of protein malnutrition. Caloric malnutrition was not seen, and the pathetic wasting of prisoners

of war and individuals in certain far eastern countries was absent. On the other hand, extreme obesity due to a predominantly carbohydrate diet and associated changes in hair, skin, and nails reflected significant protein malnutrition. It is a point of pride among the people that they claim to provide meat for their families, but the physical manifestations of protein malnutrition seen in the children do not support this contention. We suspect that meat, like milk, is only available on post-pay weekends. Vitamin deficiencies were extremely common. Evidence of ariboflavinosis, rickets, and pellagra were confirmed by the two nutritionists with us, and painful chewing and swollen bleeding gums suggestive of scurvy were seen in several children.

5. NEOPLASTIC DISEASE

Neoplastic disease was not common. It is not likely that we made a primary diagnosis of malignant disease in any person, and the Papanicolaou smears of cervical mucosa in 27 individuals failed to reveal malignant change, though bacterial and mycotic infections were common. Basal cell carcinomas of the skin was suggestive on several older individuals with heavy actinic exposure. We did examine three patients who were known to have malignant disease, one of whom had been treated intensively for lymphosarcoma and was in a terminal state. Prostatic carcinoma, resected carcinoma of the stomach, and a number of breast malignancies which had been operated were seen.

6. TRAUMATIC INJUMES

Traumatic injuries were common and head injuries, injuries to the cervical and lumbar spine, and thoracic injuries, resulting in fractured ribs, were seen or confirmed on X-ray. It was remarkable how few of these had received what would be considered adequate follow-up care.

7. CONGENITAL LESIONS

Congenital lesions were seen with some frequency. Most commonly, harelip, cleft palate, pilodinal cysts, and two children were seen with congenital cataracts, the genesis of which was not clear. Four children with congenital strabismus were seen. We were disturbed by the fact that one six-year-old child with cleft palate had not been operated, and had experienced continuous feeding problems, including reflux of food and liquids through the nose.

8. DEGENERATIVE DISEASE

Degenerative disease in older individuals was common, including arteriosclerotic heart disease, arteriosclerosis obliterans, and osteoarthritis, particularly of the hips, knees and hands. Degenerative and actinic changes of the skin were often associated with small, basal-cell carcinomas which we could document by clinical examination, but which were not biopsied.

9. DENTAL PROBLEMS

Dental problems existed in every individual we examined. These included advanced dental caries, pyorrhea alveolaris and other evidence of periodontal and root-canal disease.

10. SPEECH, HEARING, VISION

Speech, hearing and vision defects were common, particularly in children. Congenital and acquired strabismus and cataracts were seen, and the survey team was impressed by the high incidence of hearing loss in children with chronic ear infections which had been untreated.

11. MENTAL, EMOTIONAL, DEVELOPMENTAL, AND LEARNING DISORDERS

Mental and emotional disorders were common, though difficult to assess during our brief examinations. Developmental, behavioral, and learning disorders were also difficult to assess, but we commonly saw children far behind in school, in some cases in which we were able to document previously unrecognized hearing loss or loss of visual acuity.

From the combination of our history and physical examination, coupled to the laboratory and X-ray studies and our overall clinical impression, the following general observations can be made:

1. Malnutrition in adults, particularly the aged and in growing children and infants, was commonplace. This was manifest clinically by the presence of rhagades, chelosis, hyperkeratosis, night blindness, keratitis, blapharitis, photophobia, and skin lesions resembling those of an expoliative dermatitis. These observations confirm and extend earlier findings by the "Select Study on Human Nutrition" made in this same community two years earlier. Manifest evidence of vitamin A, D, and B-comples deficiencies were clinically observed.

2. Chronic skin disease, including superficial fungal infections, impetigo, and exfoliated dermatitis occurred in a significant number of patients. Many of the older individuals who had worked in the sun most of their life had multiple superficial skin tumors, several of which were thought clinically to be basal-cell carminoma. We did not see lesions of squamous cell carminoma.

3. We found a high incidence of visual and hearing loss, particularly in the aged and in school-aged children. Growing evidence suggests that hearing loss in children, arising from untreated or inadequately treated otitis media, may serve as a "tracer" disease reflecting inadequacy of health care. For this reason the National Science Foundation has inaugurated a long-term study of hearing loss.

4. Intestinal parasitism was extremely common and had, in most instances, never been treated, except with home remedies by "curanderos."

5. Metabolic disease, including diabetes mellitis and thyroid disease was frequent, and we were particularly impressed by the number of palpably enlarged thyroids representing endemic goiter.

6. Invariably, the mothers showed evidence of the "multiple pregnancy syndrome," which includes chronic anemia, weakness, in many cases, and evidence of unrepaired cervical lacerations. This is an empiric syndrome which is diagnosed retrospectively in a mother with multiple births over a short span of time. This is largely an intuitive diagnosis, but was commented upon repeatedly by the examining physicians.

7. One of the most disturbing aspects of our survey was the evidence of neglect of dental hygiene and proper oral care. Furthermore, in the presence of this destruction of teeth and gums, we saw little evidence of repair of carious teeth and no evidence of prostheses. Pyorrhea alverolaris was common.

8. We saw uncorrected congenital deformities which would have responded well to appropriate surgical therapy.

9. Rehabilitation of patients with nerve injuries, with fractures, and with strokes leading to hemiplegie and hemiparesis was unknown. Not one single individual with a residual impairment of gait or motor function had enjoyed the benefits of rehabilitative care, aside from that associated with return to work at a lower level of productivity.

10. We saw patients with a history of seizures. During our clinic visit, one young man of 16 had a grand mal seizure which started as a Jacksonian march, suggesting localization, but no neurological workup had been performed.

11. Multiple back deformities were seen, including scoliosis and kyphosis, occasionally due to injury but in a number of cases no explanation was forthcoming from the patients as to the genesis of their deformity. Undiagnosed back, hip, and lower-extremity pain was a common symptom in young individuals, but was difficult to document on physical examination. Symptomatically this pain resembled that of degenerative osteoarthritis, usually found in older people.

12. Active pulmonary tuberculosis was discovered by X-ray, as well as sarcoidosis, a pulmonary disease or uncertain etiology.

13. Degenerative diseases of the heart and great vesséls, was extremely common, as was hypertension.

14. Anemia was not a common finding in these individuals. When it was observed, it was usually due to a combination of iron deficiency, protein malnutrition, and intestinal parasitism. The "multiple pregnancy syndrome" may also have been important in some of the anemia we observed.

In this recounting, it is difficult to convey the overall impression of our group in an objective fashion. Four consecutive days of an endless parade of illness, deformity, disability, and human suffering exerted a profound and demoralizing effect upon our team. While we had reason to question the wisdom of having brought students with us, the demoralizing effect was as profound on older physicians as on young medical students.

The people whom we examined represent an almost "pure culture" of a society totally peripheral to the influence of American health care. In a nation where levels of specialty care in medicine have achieved laudable heights, this group has not yet found its way to our most rudimentary care facilities. Such simple neces-

sities as glasses, false teeth, braces, hearing aids, dental repair, rehabilitation, plastic surgery, repair of congenital deformities, maintenance of simple hygiene, and repair of cervical lacerations following childbirth, this population—uniquely—seems to have never attained. The specialities of plastic surgery, obstectrics and gynecology, pediatrics, surgical opthalmology, and otorhinolaryngology have no meaning to these people, for they have never had access to this high level of professional care.

The health survey team would wish to stress once more the relative ease with which we were able to document the presence of disease, and the absolute impossibility of ascribing cause to these conditions. This is an important distinction, for if we are to correct these conditions, we must know and understand where the defect lies. If medical and dental care is too expensive, we need to know this. If there are simply not enough physicians and dentists and other health facilities in this region, this must be emphasized. If socio-cultural barriers exist, we need to learn to work within these limits. If religious ethic prevents planned parenthood, we need to find ways to reasonably approach such structures. If there are injustices and cruelties which throw up insurmountable hurdles to the acquisition of food, of transportation to and from health facilities, and of entry into hospitals, we need to know of this.

Of one fact we have become convinced. If we make significant strides in the delivery of health care to these individuals and do not change the social environment in which they exist, including food, clothing, housing, education and sanitization, we will have done little to change the fundamental situation. Because the major causes of these manifold social ills are largely economic in nature, any effort we make must be tempered with an understanding of the deficiencies of our entire social structure, which tend to punish, selectively, the poor of our society. If this Committee addresses itself to medical care problems, specifically the doctor-patient relationship, and fails to grasp the complexity of the deficiency in the total life style and needs of this population, then our myopic attempts to achieve good health care will fail.

In an attempt to achieve objectivity in this report, charges will be linked to suggestions for change. I feel that physicians, and other health providers are individually responsible for a form of apathy and indifference which is generated by long association with illness. Each physician must retain his sensitivity to illness and its effect on the community as a whole. He must be willing to stand up and call attention to urgent local health needs. It requires courage to refuse to tolerate these conditions. He and his colleagues must search for ways to more effectively participate in community health programs. Furthermore, in every poor community I have visited in the past two years, the physician's primary or follow-on fee constitutes the single most significant barrier in the minds of the poor to their seeking early medical help. Physician collectively, throughout their county, state, and national medical associations, both black and white, are responsible for failing to exert leadership in our country for the development of health care programs which would, at a local level, bring resolution to these problems.

I feel that elected officials, particularly county judges sitting on commissioner courts or in other administrative occupations, hold the key over local options, both in the solicitation of state and federal funds, and more importantly, how these monies are spent in their counties.

I believe that hospitals, operating as non-profit, tax-exempt corporations, both public and private, have failed to exercise innovation and courage in the development of community programs which would reach out to the poor and almost-poor, and eliminate such hurdles to care as the "means" test.

We believe that the Federal Government, through well-intentioned legislation, has in some cases, created absolute barriers to better health care. A recent case in point involves Medicare legislation which requires that registered nurses be on duty on all shifts in hospitals receiving Medicare funds. This has recently resulted in the imminent closing of at least six hospitals serving the Rio Grande Valley, which, while giving limited health care, nevertheless provided a critical service for the migrant worker and his family. Additionally, Medicare legislation does not specifically pay for immunization for these individuals and we are now reaping the harvest of this shortsightedness in our current polio epidemic.

Finally, many corporations in our country have placed self interest too far above community concern and have failed to exert that leadership which their economic strength could have allowed. Insurance carriers have set patterns for health care compensation which have encouraged *over utilization* of our hospi-

tals, and increased costs in insurance premiums, which have become prohibitive for the poor. The renewed attempts of the valley migrants to unionize may provide them the strength to bargain collectively to force such issues as a fair wage and decent living conditions and adequate health care insurance. The recent pressures to develop a form of National Health Insurance and group, pre-paid health coverage may provide a direct, and overdue, remedy for these injustices.

In a wholly different vein, and, perhaps, to move the cynic, a pragmatic approach to the nutritional and health problems of the poor may have greater impact than an appeal to altruistic sentiments. What we are doing to the poor in our country today is simply *bad business*. We are losing valuable man-hours of productive labor by allowing this human wastage to continue. In a recent study, Correa and Cummins (Am. J/Clin. Nutrition: 23:560–565. May 1970, demonstrate that increased caloric consumption accounted for 5% of the growth of the nation product, in nine Latin American countries, a contribution nearly as great as education. We have failed to conduct the business of the nation in a businesslike fashion.

The findings described here are not limited to the Rio Grande Valley, to the Mexican-Americans, or to the migrant worker. Disease of this magnitude we have seen in the ghettoes of American cities, and in rural areas throughout the nation. I would state emphatically that enough evidence is now at hand for us to roll up our sleeves and get to work.

APPENDIX

List of Field Foundation Participants in Hidalgo-Starr County Health Survey March 3–8, 1970

Iradell Bell
Joseph Brenner, M.D.
Robert Coles, M.D.
Larry Culpepper
Peter B. Edelman
Anita Garcia
Sheldon Greenfield
Felicia Hance, M.D.
Gordon Harper, M.D.
John Hutchinson
Melvin Krant, M.D.
Richard Le Blond
David Leonard
Harry Lipscomb, M.D.
Andrew MacMahon, M.D.
William Miller
Donald Muirhead, M.D.
John Naiden
Buford Nichols, M.D.
Robert Nolan, M.D.
David Osler
Stephen Prescott
Robert Rosenberg, M.D.
D. E. Sagov, M.D.
Milton J. E. Senn, M.D.
Raymond Wheeler, M.D.
Carey Windler
Carol Winograd

Enumerative Listing of Medical Conditions Observed in Hidalgo-Starr County Health Survey

1. chronic sinusitis
2. chronic bronchitis
3. otitis media with perforation
4. unexplained adenopathy
5. failure to thrive
6. positive serology
7. T.B.
8. T.B. on I.N.H.
9. costochronditis
10. osteoarthritis
11. scoliosis
12. fractured rib, untreated
13. hypertensive cardiovascular disease
14. obesity
15. peptic ulcer
16. tapeworm
17. ascariasis
18. pin worms
19. hypertension, untreated
20. fungus infection of skin
21. varicose veins with thrombophlebitis
22. dental caries
23. epistaxis, recurrent
24. tinea corporis
25. I.V. septal defect
26. diabetes mellitus
27. splenomegaly
28. ovarian cyst
29. anemia
30. enuresis (age 12)
31. hematuria
32. bronchial asthma
33. bursitis
34. reactive depression
35. cholecystitis/cholelithiasis
36. cataracts, unoperated
37. hernia, unoperated
38. protein malnutrition

39. hyperkeratosis
40. conjunctivitis
41. impetigo
42. glaucoma
43. sarcoidosis
44. cardiomegaly
45. goiter
46. pyelonephritis
47. hearing loss
48. gastritis
49. glomerulonephritis
50. hemorrhoids, bleeding, untreated
51. pellagra
52. ariboflavinosis
53. epilepsy
54. seborrheic dermatitis
55. alopecia areata
56. cervicitis
57. rickets
58. hyperthyroidism
59. visual loss, untreated
60. infantile diarrhea
61. cerebral palsy
62. untreated fractured knee
63. scabies
64. chronic pancreatitis
65. iodine deficiency goiter
66. unbiopsied neck nodule, 3 cm.
67. diverticulitis
68. iron deficiency anemia
69. endometritis
70. feeble-mindedness
71. cystitis
72. urethritis
73. esophagitis
74. chronic alcoholism
75. exposure to pesticides
76. cleft palate, uncorrected, 6 years
77. spinal cord lesion with L_{2}, 2 deficit
78. congestive heart failure
79. maduromycosis
80. tonsillitis
81. psoriasis
82. recto-vaginal fistula
83. paraplegia, field injury
84. mental retardation
85. thrush
86. amebiasis
87. bilateral ptergium
88. ruptured lumbar disc
89. hiatus hernia
90. pyorrhea alveolaris
91. arteriosclerosis obliterans
92. tendon injury, unrepaired
93. umbilical hernia
94. laryngotracheobronchitis
95. bilateral scortal hydrocele
96. birth defect
97. club foot
98. G. I. bleeding
99. congenital heart disease
100. migraine
101. strabismus, uncorrected
102. cellulitis
103. craniostenosis
104. cancer of prostrate
105. heart block
106. infantile hemiplegia
107. cystocele
108. emphysema
109. vaginal bleeding
110. broken hip

APRIL 2, 1970.

DR. RAMIRO R. CASSO,
McAllen, Tex.

DEAR DOCTOR CASSO: I enclose herewith copies of the bacteriological analysis of water samples derived from the colonias in Hidalgo and Starr Counties during our recent visit. These analyses have been performed by the Laboratories of the Texas State Department of Health.

Of the eight samples[1] from our first study, involving the Colonies of El Gato, Los Velas Progresso, Rancho Colorado, Llano Grande, and Aqua Dulce, six of these showed the presence of coliform organisms.

I hope measures to correct this problem can be inaugurated at once.

Sincerely,

HARRY S. LIPSCOMB, M.D.,
Director, Xerox Center for Health Care Research,
Baylor College of Medicine.

[1] Because of mechanical limitations and the condition of the forms submitted they could not be reproduced for this hearing record but may be found in the files of the subcommittee.

Contribution of Nutrition to Economic Growth

(By Hector Correa,[1] M.S.C., Ph.D. and Gaylord Cummins,[2] B.A., Ph.D., M.P.H)

Malnutrition may retard the economic growth of poor countries in many ways, as has been summarized by Berg (1). Malnutrition reduces life expectancy and so reduces the productive years to be expected from newly born children. By reducing resistance to disease, malnutrition may increase absence from work. Some specific nutritional deficiencies limit productivity, as for example, those that may cause blindness. The mental and physical growth of poorly fed children is retarded, so that their productivity as adults is reduced. Malnutrition affects the ability of children to learn and may even cause death. Therefore, it reduces the number of workers available and increases the cost of training. Low levels of calorie consumption restrict productivity on the job. As Berg (1) also indicates, there is only fragmentary quantitative information concerning the relation between nutrition and productivity, and none of it, at least in its present form, permits one to say whether the contribution of better nutrition to economic growth is large, small, or negligible. Such information is important because the decisions that depend on it are crucial. These include, for example, decisions concerning the allocation of scarce foreign exchange between imports of food and other goods, the allocation of new investment between agriculture and manufacturing and even the allocation of a nation's resources between production for current consumption and for growth in the stock of capital equipment. To the extent that such choices affect nutrition and that present and future output depend on the nutritional status of workers, these choices are presently being made very nearly in the dark. To put the matter a little differently, the knowledge that nutrition contributes to economic development is not, by itself, very helpful. There are innumerable ways of using resources that contribute to development, but resources are limited and choices must be made. It is, therefore, also essential to know to what extent nutrition contributes to economic development.

Accordingly, we wish to report some estimates of the contribution of better nutrition to economic growth. The estimates cover 18 countries and the period from 1950 to 1962. The countries enjoy per capita incomes ranging from $300 to $3,000/year and are evenly divided between an advanced group from Europe and the United States, and a less advanced Latin American group. The estimates are confined to the effects of increases in calorie consumption on work capacity and, as a consequence, on the growth of total output. For this reason, of course, they tend to understate, perhaps greatly, the total contribution of better nutriion.

In an exercise of his kind it is impossible to achieve anything approximating the usual precision found in the biomedical sciences. It is, nevertheless, important to do what is possible, and the contribution which we could measure is striking for the Latin American countries, even after allowing for all the errors and omissions.

DATA AND METHODS

An estimation of the contribution of increased calorie consumption to economic growth requires three steps and three sets of methods. One must first be able to measure the growth in output due to the increase in the productive capacity of labor. One must then be able to estimate the increase in productive capacity of labor due to increased calorie consumption. Finally, one must ascertain the changes that took place in the calorie consumption of workers.

Tinbergen (2), Solow (3), Correa (4), Denison (5), and others have developed a method for measuring the contributions of increases in productive inputs (labors, capital, education, et cetera) to growth of total output. We used this method in the first step. As applied here, it rests on the following basic equation:

$$r_T = a r_E + a r_N + A$$

where r_T is the rate of growth of total output; a is labor income as a fraction of total output; r_E is the rate of growth of the productive capacity of labor attributable to better education; r_N is the rate of growth of the productive capacity of labor attributable to increased calorie consumption; and A is a residual reflecting such factors as technological progress, growth in the stock of physical capital,

[1] Associate Professor, Department of Economics and Center for Population and Family Studies, Tulane University, New Orleans, Louisiana.
[2] Assistant Professor, Department of Tropical Medicine and International Health and Department of Economics, Tulane University.

and the various effects of better nutrition that we could not measure separately. If, for example, the working capacity of the labor force increased by $r_N \cdot 100\%$ because of better nutrition and if the ratio of labor income to total output were a, then one could conclude that better nutrition accounted for $ar_N/r_Y \cdot 100\%$ of the growth in total output. The decision to study explicitly those factors that contribute to economic growth or those that are to be set aside under A, depends entirely on the availability of data and the purpose at hand. We present estimates of the effects of education in order to compare them with the effects of increased calorie consumption.

The plausibility of the findings depends in part on the credibility of the relationship just described. A brief explanation is, therefore, required of the assumptions from which it is derived. There are two. First, the economy in question works as if it were "perfectly competitive," namely, the prices of goods and services were determined by supply and demand in open markets. Some such assumption is indispensable, and generally this one has proved to be the most useful. (It underlies, for example, all measures of the "economic burden" of particular diseases.) Secondly, the economy is characterized by "constant returns to scale." This means that if all productive inputs were to increase in a given proportion, output would increase in the same proportion. Again some such assumption is unavoidable, and this one has proved to be the most useful.

The second step in estimating the effect of increased calorie consumption entails ascertaining the relation between calorie intake and work capacity. From experimental data, Lehmann et al. (6) have estimated the relation between calorie intake and work capacity for four categories of work, classified according to how heavy the work is. They provide detailed descriptions of kinds of occupations that fall into each category, and with these data we were able to establish a fair correspondence between their classification and the United Nations international classification of industries (7). Their results, arranged according to the United Nations industrial classification, are shown in Table I below. For Each industrial group the table shows for various levels of calorie intake the work done as a percentage of the maximum that could be done with adequate nutrition in the same way at both ends of the period studied. For this reason, too, the errors in the estimates of growth in capacity to work would be smaller than those contained in the estimates of capacity to work for single years.

The methods described so far yielded estimates of actual annual intakes of male adults for each industrial group and each country. Before these could be compared with the data in Table I we had to make several further adjustments. The data in table I were derived for a temperature of about 10 C and for men between 20 and 30 years old. We could not ascertain their weights. We assumed an average weight of 65 kg for all countries. This is probably overestimated for the Latin American countries and underestimated for the others. The resulting errors, however, are probably small. A reduction in weight of 5 kg reduces required intake by about 100 kcal/day (8). An error of 100 kcal/day, in turn, would produce an error of about 5% in estimated working capacity. As before, the same error would occur in the results for both the initial and terminal years, so that the error in the estimated rate of growth of working capacity would be much less than 5%.

Data are available concerning the relation between calorie requirements and average temperature (8), and also for average temperatures in the 18 countries (9, 10). The basic temperature data are for areas within each country. We compound countrywide averages using area populations as weights and then converted the estimated calorie intakes into the equivalents for an average temperature of 10 C.

The effect of additional calorie consumption on work capacity presumably decreases with age. To allow for this effect of differences in age, we assumed that the effects of increased intake shown in Table I held exactly for ages 15–30 and diminished continuously over older ages, reaching zero at age 60.

In regard to sex differences, we assumed that for each age group women's capacity to work increased in the same proportion as men's.

The steps just described determined estimates of the growth in productive capacity of the labor force due to increased calorie consumption, r_N, for each country. From these estimates and national income data (7) we computed the rate of growth of output attributable to increased caloric consumption, $ar_N \cdot 100$ equals percent increase.

There is no need to describe here the details of the method by which the value of the contribution of education was estimated. In the case of the advanced countries, we took the estimates directly from Denison (5). Using comparable data and methods, estimates were derived for the Latin American countries.

RESULTS AND DISCUSSION

The estimated contributions of increased calorie consumption to the growth of output for the 18 countries are shown in Table II. The contribution in the advanced countries was practically nil. Although there was considerable variation among the Latin American countries, the contribution there was in most cases substantial, averaging almost 5% of output growth. This was nearly as large as the contribution of education. The results of these comparisons are not surprising; production processes in the less advanced countries make comparatively modest demands in relation to educational attainment and comparatively heavy demands on physical health. The reverse tends to be true of advanced countries.

TABLE II.—CONTRIBUTIONS OF INCREASED CALORIE INTAKE AND EDUCATION TO GROWTH OF NATIONAL PRODUCT IN SELECTED COUNTRIES 1950–62

Country	National product percent rate of growth/year	Increased calorie intake: Percent rate of growth of national product contributed	Increased calorie intake: (B) as percent of (A)	Education: Percent rate of growth of national product contributed	Education: (D) as percent of (A)
	(A)	(B)	(C)	(D)	(E)
Latin America:					
Argentina	3.19	0	0	0.53	16.5
Brazil	5.43	.23	4.2	.18	3.3
Chile	4.20	.05	1.2	.20	4.8
Colombia	4.79	.31	6.4	.20	4.1
Ecuador	4.72	0	0	.22	4.9
Honduras	4.52	.41	9.1	.29	6.5
Mexico	5.97	.60	10.1	.05	.8
Peru	5.63	.43	7.6		
Venezuela	7.74	.18	2.4	.19	2.4
Average	5.13	.25	4.6	.23	5.4
Europe and United States:					
Belgium	3.20	.02	.6	.43	13.4
Denmark	3.51	0	0	.14	4.0
France	4.92	.05	1.0	.29	5.9
Germany	7.26	.16	2.2	.11	1.5
Italy	5.96	.16	2.7	.40	6.7
Netherlands	4.73	0	0	.24	5.1
Norway	3.45	0	0	.24	7.0
United Kingdom	2.29	.01	.4	.29	12.7
United States	3.32	0	0	.49	14.8
Average	4.18	.04	.8	.29	7.9

Since increased calorie consumption by itself raised output almost as much as did education, the aggregate effect of better nutrition on output may well have exceeded that of education. For some purposes it would be more important to know the effect of better nutrition on growth of output per capita than its effect on growth of total output. At present there is no satisfactory method for measuring the contribution of health to growth in output per capita. This is chiefly because improved health affects growth of population as well as that of output. But in the case of nutrition, the effect on population growth probably is comparatively small; since total output grew more than twice as rapidly as output per capita, increased calorie consumption may, on the average, have caused as much as 10% of the growth in output per capita.

Existing data are inadequate for systematic estimation of the contributions of nutrition and education to the economic growth of very poor countries where the per capita incomes are less than $200/year. One may comment, however, about the contribution of increased calorie consumption in those countries. As income and output grow, the proportion of the labor force engaged in occupations

requiring relatively high calorie consumption tends to decrease (11). The poorer a country is, the greater the effect of increased calorie consumption on economic growth tends to be. Among our 18 countries the coefficient of correlation between the contribution of increased calorie consumption and the level of per capita income is —0.56 and the significance is at the 5% level. These considerations suggest that increased calorie consumption contributed even more to the economic growth of very poor countries than to that of the Latin American group.

Our estimates clearly rest on a series of more or less questionable assumptions. This was unavoidable, partly because the necessary national data are either lacking or defective, and also the experimental evidence concerning a number of relationships involved in the method of estimation is incomplete. It would have helped, for example, to have had data on the distribution, by occupation, of workers' consumption of calories. The estimates also could have been improved had there been data similar to those in Table I but derived for older groups of workers. In any event, the description of the methods we used indicates the information necessary if one is to estimate the economic consequences of improved nutrition, or, for that matter, of any improvements in health that affect capacity to work.

SUMMARY

Malnutrition may in many ways impede the economic growth of poor countries. Even though important policy decisions depend on quantitative data concerning the effect of nutrition on economic growth, there is little such information available. We have estimated effects of increased calorie consumption on the productive capacity of the labor force and, therefore, on the economic growth, of 18 countries from 1950 to 1962. For nine Latin American countries increased calorie consumption accounted, on the average, for almost 5% of the growth of national product. This was nearly as great as the contribution of education. Increased calorie consumption had a negligible effect on the economic growth of nine advanced countries. It probably causes a substantially larger fraction of the growth in output per capita than of the growth in total output in poor countries. Also, its effect is probably greater in very poor countries than in the Latin American group.

REFERENCES

1. Berg, A. D. Malnutrition and national development. *J. Trop. Pediat*, 14 : 116. 1968.
2. Tinbergen, J. Zur Theorie der langfristigen Wirtschaftsenwicklung. *Weltwirtschaftliches Arch.* 55 : 511. 1942.
3. Solow, R. M. Technical change and the aggregate production function. *Rev. Econ. Stat.* 39 : 312. 1957.
4. Correa, H. *The Economics of Human Resources.* Amsterdam : North-Holland. 1962.
5. Denison, E. F. *Why Growth Rates Differ.* Washington, D.C. : Brookings Institution, 1967.
6. Lehmann, G., E. A. Muller and H. Spitzer. Der Calorienbedarf bei gewerblicher Arbeit. *Arbeitsphysiologie* 14 : 166. 1950.
7. U.N. Statistical Office. Dept. of Economic and Social Affairs. Statistical Yearbook. New York, 1951–1966.
8. Calorie Requirements. Report of the FAO 2nd Committee on Calorie Requirements. *F.A.O. Nutr. Studies*, no. 15. Rome. 1957.
9. *U.S. Dept. Agr. Yearbook of Agriculture.* Washington, D.C. : U.S. Govt. Printing Office. 1941.
10. Pan American Union. *America en Cifra 1967: Situacion Fisica, Territoria y Clima.* Washington, D.C., 1967.
11. Kuznets, S. Findings on industrial structure of labor force and national product. *Six Lectures on Economic Growth.* Glencoe, Ill. : The Free Press. p. 43.

* * * * * * *

PREPARED STATEMENT OF RAMIRO R. CASSO, M.D., GENERAL PRACTITIONER, MCALLEN, TEX.

Senator Mondale, members of the Senate Subcommittee on Migratory Labor. I am Dr. Ramiro R. Casso of McAllen (Hidalgo County) Texas. I am a Doctor of Medicine and have been in the general practice of medicine and surgery in McAllen, Texas, for the past 13 years.

My medical practice consists in treating from 50 to 100 patients per day, the vast majority of whom are poor people. Probably as many as 80% of my patients are farmworkers, some migrants and others ex-migrants who now do farmwork, packing shed labor, or other similar seasonal work locally.

Suffice it to say that my people are among the poorest in this affluent society. Because of their wretched earnings our people suffer all of the consequences of being poor. There is severe malnutrition among large numbers of them and this enhances their susceptibility to all forms of disease. It is no mystery that nutritional anemia, protein malnutrition, diarrheas, tuberculosis, skin infections, influenzas, pneumonia, birth defects, prematurity and neonatal deaths are much more prevalent among the farmworkers' families than among the general population.

Mr. Chairman, the health survey conducted in March, 1970, in Hidalgo County by the very eminent physicians assembled by the Field Foundation was a milestone in the area of health in South Texas for several reasons. First, it documented the high incidence of malnutrition, vitamin deficiencies, and disease which was suspected by many to exist. Secondly, a very excellent presentation of the findings was made by Dr. Harry Lipscomb of Baylor Medical College to a meeting of the Hidalgo-Starr County Medical Society. Thirdly, and most important of all, Dr. Lipscomb was successful in challenging the Medical Society and Dr. Carl Love of McAllen, his former student and presently the president of the Hidalgo-Starr County Medical Society, to take the lead in mobilizing the medical community in search of solutions to the enormous medical problems of the area.

Those solutions, if they are implemented, will include ending the present hesitancy of our hospitals to serve all of the people, rich and poor alike. At the McAllen Hospital, where I work, we have the latest x-ray and laboratory equipment, very excellent surgical suites and a completely equipped coronary care unit. Hopefully, in the future more poor patients will be able to avail themselves of these facilities.

Those solutions, if they are implemented, will include an expansion of the public health activities in Hidalgo County. At present, these activities are limited to Tuberculosis detection, follow-up on contagious diseases, and immunization of children. The inadequacy of our immunization program was pointed out during the past two months when in Hidalgo and Cameron Counties, we had nearly all the suspected to have been due to poliomyelitis. Beyond the efficient carrying out of these activities, we hope the public health officials will provide forms of treatment, outreach, and care which serve the poverty community.

Those solutions, if they are implemented, will also include the expansion of the Migrant Health Program in this area of Texas.

In the meantime, those of us who are concerned, do what we can.

I have been personally operating a Charity Clinic at the Farmworkers Service Center in McAllen at the invitation of Tony Orendain who also heads the Farmworkers organization for Cesar Chavez in the Rio Grande Valley. With the aid of Sister Sharon Stanton, a Catholic nun who is also a Registered nurse, we hold a two-hour clinic 3 times a week. We treat from 40 to 120 patients a week, but are limited by the lack of adequate equipment, examining rooms, and the absence of X-ray or laboratory facilities. At this clinic we treat only those who do not have Medicare, Medicaid or Migrant Health Coverage, and who have no money to see a private physician.

It is very discouraging and depressing to attempt to operate a charity medical clinic with very limited resources. I want to tell you something about how the Farmworkers clinic was started.

Last year, when I received the first letter that Tony Orendain wrote to all the members of the Hidalgo-Starr County Medical Society, asking us to start a medical clinic, I visited the United Farm Workers Service Center in McAllen and discussed the matter with him at length. As it turned out, Tony was able to spare a corner 10 feet wide by 12 feet long and that was where the clinic was started. Tony obtained an old table that I used for an examining table and with a few sheets of sheetrock constructed partitions to provide the necessary privacy for physical examinations.

I obtained some medications and medical supplies from my office and we began to treat the sick. By word of mouth the word was passed in the Colonias, and though many of the sick do not have transportation or do not even know that the clinic exists, yet during the January 1970, influenza epidemic we were seeing from 45 to 50 patients each day. It became obvious that we couldn't continue this operation out of a 10' by 12' locale, so I offered Tony Orendain that I would personally pay the first month's rent in an adjoining building if he would assume the responsibility thereafter.

He accepted and we moved to our present location which is grossly inadequate in all respects, but which at least gives us 4 to 5 times more space than we had before.

Gentlemen, the lighting in the clinic is very poor. Somebody has to go clear across the room to plug in the single examining lamp that we have. We have no examining tables per se, we have no medical cabinets. We do not have a certain supply of injectable medications except those that I bring from my private office; we have no refrigerator to keep our medicines in; we do not have a laboratory to do a simple blood count or urinalysis or an X-ray machine to take a chest X-ray. Needless to say, a lot of diagnostic guess work takes place in this clinic, but this is better than no clinic at all. I rely heavily on the use of injectables, gentlemen, because very frequently the medication that I inject into their bodies is the only medication they will receive, since they very frequently do not have the money to fill a written prescription.

The diseases most frequently seen in the Farmworkers Clinic are those seen in any general practice office where poor people are treated, namely, many nutritional anemias, protein malnutrition, upper respiratory infections, draining ear infections, pneumonias, diarrheas with all degrees of dehydration, and many skin infections.

Mr. Chairman, we need to attract more physicians to the many pockets of poverty throughout the country. We need to de-emphasize specialization in medicine and encourage more medical graduates to go into general practice. We need a total commitment from the Congress and the Executive to provide the facilities and the manpower to treat the ailments of all of our citizens regardless of their ability to pay. We pray that you, Mr. Chairman, and your colleagues will search for the legal machinery that can bring this about.

* * * * * * *

PREPARED STATEMENT OF DR. MILTON J. E. SENN, YALE UNIVERSITY, NEW HAVEN, CONN.

My concern is with the long-term effects of nutritional and psychological deprivation. Studies of people who are underfed show that this leads to starvation and malnutrition, even death. Inadequately fed pregnant women give birth to babies who are undersized, have an inadequate development of the central nervous system; and if the underfeeding persists, this leads to a predisposition of other diseases, especially infections, and to a variety of deficiency diseases involving the skin, the mouth and teeth, the hair, and a variety of internal organs.

There are at least three ways in which inadequate nutrition impairs learning. The first, is through a direct effect on the developing nervous system in utero and in the postnatal and weaning periods. Such impairment of growth and differentiation of the central nervous system is disturbed in a way that is not corrected by feeding at later ages. The second way, in which nutrition affects child learning is by making him susceptible to infections, again with some possibility of central nervous system damage. Thirdly, malnutrition affects learning by interfering with the energy levels, the level of attention; and a direct consequence of this is a diminution in the number of days of school attendance, often leading to school drop out.

84-852 O - 72 - 12

Underfeeding also leads directly to the development of behavior problems, some of which may be classified as anti-social acts and delinquency.

In examining the families in Texas, I was impressed with the number of complaints from the adults about backaches, headaches, abdominal pain, and lassitude. A number talked about being chronically depressed and discouraged. I do not think it too farfetched to consider these conditions psychosomatic illnesses, directly ascribable to the living and working conditions of the patients.

I conclude, that malnutrition and other conditions of health represent intergenerational or transgenerational problems. The degree to which a child is at risk in health, and in psychological development, must be considered not only in terms of the contemporary circumstances in which he is living and the details of his own history, but also within the context of his parents' physical status and their own developmental and psychological histories. The relationship this is cyclical and intergenerational. There is a contagiousness of the spirit and anxiety and hopelessness from parent to child as well as a contagion of infectious disease.

Physicians as well as those other people, such as members of Congress, who are concerned with the health of our people, must then be concerned not merely with change in a given generation, but with the intergenerational influences on health. Malnutrition is not a crisis phenomenon in Texas among the migrant workers. It has become a condition of life; stable, persistent, pervasive, ever endangering the health of scores of people. What we must develop are means of implementing our concern by remedial and preventive measures which will affect all facets of health, across the generations, in order to assure subsequent generations of being free of the serious ills now overpowering members of this generation.

EFFECTS OF DEPRIVATION (NUTRITIONAL, PSYCHOLOGICAL) IN PREGNANCY, INFANCY AND EARLY CHILDHOOD

1. Nutritional deprivation:
   - Underfeeding:
     - Starvation and malnutrition.
     - Death.
     - Growth retardation.
     - Inadequate development, especially CNS.
   - Inadequate feeding:
     - Vitamin, protein, mineral deficiencies.
     - Many Deficiency Diseases.
     - Predisposition to other diseases, especially infections.
   - Overfeeding: Obesity.
2. Psychological deprivation:
   - Underfeeding:
     - Hunger.
     - Intellectual impairment:
       - School learning problems.
       - School drop-out.
       - Poor work records.
     - Behavior problems:
       - Anti-social acts.
       - Delinquency.
     - Mental Illness:
       - Psychosomatic illness.
       - Depressions.
       - Drug abuse.

* * * * * * *

PREPARED STATEMENT OF GORDON HARPER, M.D., TRAINING IN PEDIATRICS, BOSTON, MASS.

My name is Gordon Harper. I am a physician, in the second year of pediatric training in Boston. I participated in the March trip to McAllen, Texas, and, because the Northerner sojourning and muckraking in the South is legitimately suspect in both Southern and Northern eyes, I have since visited other areas where migrants live and work in Connecticut and Michigan.

Much testimony has already been presented about the number of patients we saw in McAllen, the kinds of diseases they presented, and how these conditions arise from poverty and discrimination. I would like to present a particular case to illustrate what we are talking about.

A BABY WITH CELLULITIS

The first day we were working in Dr. Casso's clinic, a young mother from Pharr brought in a baby, perhaps a year and a half old, complaining that his head and neck were swollen. He had been well, she told us, until three days previously, when insect bites on his scalp became infected. During the succeeding days, the infection spread and the baby grew less active and was not eating well. He developed a fever and now just lay about, showing no interest in those around him. Examining the baby, we found him well developed and fairly well nourished, but acutely ill, "toxic" as we say, lying motionless on the examining table. His temperature was 106°, his pulse was rapid and his respirations labored. One side of his scalp and neck was red-hot, swollen, and weeping. Huge lymph nodes were palpable in the adjacent areas. Pustules in his scalp, the likely location of the insect bites to which the mother referred, seemed to be the source of the infection. This was cellulitis, a bacterial infection of the skin and subcutaneous tissues, with probably spread of the infection throughout the baby's body—sepsis. We had a very sick baby on our hands.

What had this infection to do with migrant labor? First of all, it began with insect bites, a familiar summer affliction for all of us, but much more common among children who live in substandard housing. In Texas, all of us saw windows without screening, open latrines, inadequate garbage disposal, standing water, and gaping holes in floors and walls. We saw carrot chips used as ground cover—garbage in the front yard. In Michigan I visited a migrant camp, near the Aunt Jane Pickle Factory, a Borden subsidiary, built literally right next to a municipal sewage pool and garbage dump. The stench was suffocating. On all these conditions, insects and rodents thrive and attack children playing or sleeping nearby. Moreover, once exposed to such bites, babies are much harder to keep clean, and the bites are more likely to be infected, if homes have no running water. Not surprisingly, then, both in Texas and Michigan, infected bites are one of the most frequent conditions found in migrant children, directly related to the conditions they must live in. And so was this baby's initially trivial infection.

Secondly, the infection, developing over two days, received no medical attention until the mother came to us on the third day. Superficial skin infections are common problems of children in Boston or Washington as in Texas, especially when the weather is warm as it is most of the year in the Rio Grande Valley. Treated promptly, with good cleansing, a clean dressing, and antibiotics as indicated, such an infection should never reach the proportions we found in McAllen. But we learned there, as you are hearing today, how seldom poor people there see doctors. A visit to a private doctor can cost $10, plus charges for medicines. Dr. Casso has been one of the few physicians in McAllen who would see patients who could not pay, and we have seen under what a heavy case load he functions. This mother, like so many, knew of no free dispensary; there was no outpatient department or free emergency ward like those which we take for granted in the rest of the country, to which she could go. And the mother was reluctant to travel to Mexico, where many obtain cheaper and more sympathetic care, with a baby so ill. I would like you all to understand how it was very difficult for us to believe, as this mother had long since learned, that there was no place, convenient and close by, where she could take her baby when he was sick and she had no money. That is how a minor infection became a life-threatening one.

The third part of this baby's case now unfolds: what could we do about it? Again, in any of the emergency wards where we have worked, where we have been on hand to treat whoever came in; without asking who could pay or how much any indicated therapy would cost, this baby would have been hospitalized and antibiotic therapy begun without delay. But in McAllen we had to ask who could pay. The answer was that there is no Medicaid program in Texas for those not already covered under categorical welfare programs, that there are no free beds in the local hospital only one block away, and that a deposit is required for a patient's admission to that hospital. Many people in McAllen, as we will document, have been told after the birth of a child in hospital: "You pay the bill or we keep the baby." What did we do? The baby received antipyretics and a large intramuscular injection of antibiotics and was observed for six hours in the office. He then looked much better, was given another dose, and was sent home to return next day. This therapy, good bush medicine dictated by expediency, "worked" this time, but is hard to justify one block from a general hospital, the McAllen General Hospital.

Every parent of a critically ill child, faced with a disease beyond the control of aspirin and cough syrup, feels helpless and alone; for this baby's mother, however, such helplessness was compounded by three facts equally beyond her control, which should have had nothing to do with her baby's getting sick or being treated—and yet which, as we have seen, had everything to do with both: the family was poor, they were migrants, and they were Chicanos in Texas.

THE WAGES OF CONCERN

That was a piece of our experience in Texas. In Michigan, one week ago, I visited several counties where families from the Lower Rio Grande Valley—some of the same families we had seen in March in McAllen—have been picking the strawberries, are now working in the cherries, and soon will begin work with the cucumbers and tomatoes destined for our tables. In several ways, life is a bit less harsh for them there: they have some work; a food stamp program makes it more likely that they and their children may have enough to eat and several counties have programs of medical care. But their housing, in camps maintained

by the growers, is often worse than they knew in Texas; I visited a camp on the Old Mission Penninsula where 17 people were living, sleeping, cooking and eating in two rooms 8 by 18 feet under a leaking roof. Most importantly, however, the feeling of not being at home, of not belonging, of not being a part of the counties where they work, or of the country which enjoys the fruits of their labor—that feeling is still there.

The efforts of the state of Michigan and of many voluntary organizations to improve the migrants' lot is at this time, even last week when I was there, being actively opposed by those who control most aspects of the migrants' lives, the growers. The facts are simple. Federal and state housing codes set standards for migrant camps which must be met before a camp can be licensed to receive migrant-tenants. A federally funded program sponsors law students who act as legal advocates for the migrants in housing and other areas. By reporting alleged violations of the codes to a county health department, a law student earned the wrath of a grower who regarded such action (not only legal but sponsored by the government) as a challenge to his right to run "his" camps and make a profit from the work of "his" migrants as he wished. The night before I arrived in Michigan this grower, finding the student in question in one of his camps, where he was visiting friends who were tenants there, assaulted him physically. When the student escaped with his friends, leaving his care, the grower broke all the windows in the car with a steel pipe. The atmosphere the next day was tense: "For the first time in five years," said one veteran of the migrant programs, "I'm afraid someone's going to get killed."

The next day I got a taste of the same treatment. I was speaking to migrants at the side of a road, on the edge of a camp, when a grower drove up and ordered me off the premises. He boasted that he had known within three minutes of my arrival via a fleet of cars with two-way radios which the growers maintain for surveillance, that a stranger was visiting one of his camps. He accused me of trying to ruin his business by "snooping" among the workers, and threatened me with physical harm should I make any more visits to "his" migrants' camps without his approval. "If those do-gooders come on any of my land," he said, "they're never going to make it back to Lansing."

The attitudes of these rough-and-ready growers toward the workers on whose labor their profits depend, and will continue to depend, despite their headlong and much touted rush to mechanized harvesting ("We won't need all these hands a year or two from now," they argue, with the self-appointed plausibility characteristic of the man trying to justify the saving of money at the expense of human health or dignity; "And so why should we invest a lot of money in housing for them now?" are the same as the committee has heard before, and will hear again today and tomorrow, from the dominant classes in Texas and Florida. All of these attitudes serve one selfish purpose: to absolve the grower of any responsibility for the obvious and infamous short life expectancy and apathy which are the migrant's share of the American way of life. The grower will be absolved, of course, if the migrant can be successfully banished from the circle of our sympathy for such is the outcome of prejudice, whether racial, cultural, or economic in the case of Chicano migrants in Michigan, of course, it is all three.

To serve such a purpose, the migrants are dismissed as slovenly. "They live like animals," say growers who give them shacks to live in.

Or again, the growers tell us, "The migrants *like* to travel; they like to drive around and see the country, to get out of the heat of Texas in the summer, to come up to the Midwest to swim." Migrants, of course, can be found who will say they like to travel, but too many mothers show despair as they tell of having to take children out of school in early May, to begin again only in November, to believe the myth of the happy gypsy. How that myth can withstand the image of 33 people and their belongings traveling 1500 miles in an enclosed truck, with children who need rest stops every 45 minutes, to pick cherries for eight dollars a day, is a wonder of public relations beyond my comprehension.

Or the migrants, they say, are deadbeats. "I've seen one mail a money order for $500 to Texas the same day he buys $100 worth of food stamps," complains a grower whose indignation at the spectacle of government subsidies does not extend to the payments he and his fellow growers do not hesitate to cultivate.

With the migrants excluded by all these devices from the range of their sympathies, growers are able to indulge in self-pity; they have a huge personal sense of grievance, of being put upon, of not getting what they believe they are entitled to, but the scale of these grievances can only be called grotesque compared to the wasted bodies, destroyed spirits, and shortened lives which are

the migrants' lot. One complains, "With what I've got invested, and what I could earn on my own, shouldn't I be getting $60,000 a year, not just $40,000?"

With such an acute sense of personal grievance, a grower may have little sympathy left over for those around him. "Babies die all the time," says one grower, when asked about a notorious case of a nine-month-old who died last year of diarrhea and dehydration, after being refused admission to a hospital in Southwest Michigan; "why should they get so excited when one dies here?"

From this testimony and that presented today from Texas, a picture emerges of the channel in which the migrant stream flows from Texas to the Middle West; it is a hard journey through a land where money and profit move men's hearts more than does human misery, and where all kinds of self-serving rationalizations and spurious slurs on the migrants themselves seek to conceal the fundamental facts of human poverty and need, and justify indifference to them or support active interference with those who come to act on the migrant's behalf.

The kind of information the self-styled vigilantes would keep us from gathering, and the kind of tragedies which mark the migrant's travels, are illustrated by the following case history:

AN IRRITABLE BABY

In Traverse City, I learned from a young father of the illness last month of his three-month-old son. While traveling through Indiana enroute to Michigan, where his family would begin the strawberry season, this baby developed diarrhea, fed poorly, and became irritable. Diarrhea and poor feeding are common pediatric symptoms, especially in the Chicano population, where infantile gastroentitis still accounts, as it did one generation ago in the population at large, for the largest part of infant mortality. This very month, when the rest of the country has been congratulating itself on the fact that no one died last year from poliomyelitis, the most serious of the enteric viral infections, three deaths from polio have occurred in South Texas. In the absence of immunization, polio has the same epidemology, the same relation to poor sanitation, as the less dramatic forms of viral diarrhea. The unprotected outhouses, homes without plumbing, contaminated water supplies, and fields without toilet facilities already mentioned explain the frequency of these diseases; poor nutrition—the protein and vitamin deficiencies we have reported—and lack of adequate care account for the death rate in the easily treated simple diarrhea. But the other complaint, irritability, is one that gives every doctor pause, because of the possibility of meningitis. Small babies often do not show the physical findings, like stiff neck or resistance of flexion of the leg, which we look for when adults have infections of the meninges, and often the characteristic sign in infants, the bulging fontanel or soft spot, is absent despite the presence of infection. To make the diagnosis, therefore, the doctor has to be suspicious, to size up the baby as a whole, (asking, "Does he look sick?") and perform a spinal tap whenever there is any doubt at all. Anyone who's taken care of children has agonized over this decision many times, for the disease, despite the terror it strikes into parents' hearts, is treatable. Ten days of intravenous therapy with the appropriate antibiotics usually will save a three-month-old baby who would otherwise die.

In this case, however, before a doctor had a chance to consider this diagnosis, another hurdle had to be crossed: the father had to pay. At the beginning of the season, there was only enough money to get to the fields in Michigan, and the father and the hospital people argued about money. In the end, a nurse gave the father an oral medicine to give the baby, and they went out, no doctor having seen the child. They returned the next night, the baby listless and febrile, and he was admitted. Even so, the father said, no doctor saw the baby for several hours and when the diagnosis was made then, it was indeed meningitis. Intensive therapy was begun, but the baby went on to die.

The father spoke this way:

> You've got to leave a down payment before you even leave the baby there; but he was sick, man he was going to die. His mother, she suffered a lot. You know, we come over here to help these folks out with the crops, and we help a lot, picking cherries, and planting tomatoes, but they don't help us. And sometimes we need some help, too. That doctor didn't do anything, he knew the baby was going to die, and he didn't want to waste the money. I like white people, black people, but I don't know, man, I don't know. What do they care about, just money? They don't care about us. I

went to the Welfare Office and said, "If the kid survives, I won't have the money to get him out." And they said, "Sorry, we can't help you. You've got to live here two or three years, then we'll help you." I'll tell you something, man, I'm not going to that state of Indiana any more! They don't care about anybody. They don't help you at all. And you know, when they die, they're going to pay that. When they go upstairs, they're going to pay.

How does one react to this kind of spectacle? In McAllen, with all of our group, I was overwhelmed by what we saw and heard. The shock anyone would feel in such circumstances, watching an endless stream of people in pain, sick, crippled physically and emotionally, and drowned in apathy or bitterness or even one heartbreaking individual, like the thirteen-year-old boy I saw who had gone blind over several years without ever being properly evaluated or offered any rehabilitation, that shock was doubled because as a doctor, I saw how much of what I saw was preventable: how many times I have treated and seen cured patients with the same conditions as we saw there, but who would not—because they happened to have money—or just happened to be living in Boston, would not grow deaf because there was no medicine for their chronic otitis, or get dehydrated and die because there was no doctor nearby who would treat their diarrhea, or just endure a life of pain for want of analgesia, or anxiety for want of any medical comfort or pharmacologic relief. That's why I've presented these cases in the medical detail I have, to share with you the waste and horror a doctor feels seeing treatable diseases go, untreated, their crippling way.

After the initial shock, back in Boston, the mind strains every faculty to repress the shock, to blur over the agony, because you can't live with those perceptions all the time and sleep well. (And if the mere perception does that to us, imagine what the living of it does to the migrant.) The invisibility of the migrants nationally, our ignorance of them as they travel among us and load our tables wth fruits and vegetables in abundance undreamed of two generations ago, is, like all such ignorance, as Gunner Myrdal has said; opportunistic. It's how we keep going.

But if you can hold onto this vision, or be refreshed by re-reading your notes, or looking at the slides once again, or reviewing it all, as we have preparing for these hearings, with the friends and colleagues with whom we shared the experiences originally, the meaning of the migrants' lives is unmistakable; our country, the system, the way things are, or, to drop the depersonalized dodge—all of us—build the highways and the rockets and the bombs, pay for empty fields and subsidies to the rich, but have not, will not, or cannot guarantee children in our midst the elements of growth: food, health, and hope. Human needs, for those outside of our affluence, fall far down our unstated list of national priorities. The pyramid of institutionalized selfishness we call our national system cannot by the farthest stretch of the imagination be considered to maximize human welfare, despite the propaganda with which we surround ourselves. For as we do so unto the least of these....

The realization of this fact takes a strong cold grip on reality, a grip hard to maintain in comfortable caucus rooms like this or in the insulation which seems to cut this capital off from other parts of the country; and its hard in our hospitals, where we keep busy helping those who make it to the door. Terrible is the seductive power, to paraphrase Brecht, of that goodness which we do.

What does one do with such a perception? If it is correct that the diseases we have described come from the facts of poverty, migration to find work, and racial discrimination, and that a culture valuing property more than people is the ultimate barrier to changing these pathogenic factors, one can either become a prophet of the apocalypse—which is the perception behind the disaffection of young people supposedly being studied now. Or one may despair completely of change, which is the nihilistic possibility. If, however, one is disinclined emotionally or politically to both revolution and resignation then the only answer is to enfranchise the migrants with that one item for which the rest of the country seems to respect people: money. Of the practical means for achieving that—the organization of the agriculture workers—the subcommitee is well aware.

But I would say in closing, that if only to ensure simple dignity, self-respect and health for our brothers is to wait until they can buy their way into a place in our national sun, that is a terribly sad commentary on the moral economy of our country.

JULY 20, 1970.

HON. WALTER F. MONDALE,
Chairman, Subcommittee on Migratory Labor, Committee on Labor and Public Welfare, U.S. Senate, Washington, D.C.

DEAR SENATOR MONDALE: Attached are my observations after visiting the Connecticut River Valley and the labor camps there, where the Puerto Ricans who pick the tobacco are housed, fed, and virtually incarcerated.

Perhaps you would be interested in including this in the hearing record of the day on which I appeared with the Field Foundation doctors.

Sincerely,

GORDON HARPER, M.D.

REPORT OF GORDON HARPER, M.D., BOSTON, MASS., ON HIS RECENT VISIT TO THE CONNECTICUT RIVER VALLEY

In the Connecticut River Valley, the Land of the Shade Tobacco Growers Association

Driving from Boston to New York, in the valleys of central Connecticut the motorist sees large fields covered with mosquito netting which he may or may not know are tobacco plants destined for cigarmaking. He probably doesn't know that the acreage in tobacco has declined since World War II, as industry and suburbia spread over the field, or that most of the labor force, once local New Englanders, immigrants of children of immigrants—is now recruited seasonally in Puerto Rico. Several thousand Puerto Ricans work here from May to November.

The camps they live in are well concealed; several hours of driving on main and side roads, in areas full of tobacco, fail to locate a camp. By asking Puerto Ricans in the area one gets directions: to a small town where the only sign that several hundred seasonal workers live nearby is a large sign in the center of town, in English, and Spanish: No Loitering, No Littering. Thence, a mile or so from town up a gravel road to the camp, set in the woods. Behind a high chain-link fence one sees immaculate grounds, with well-trimmed lawn, climbing roses, and tall shade trees surrounding neatly kept barracks. A huge sign warns the passerby that only official cars may enter, that all others must stop at the office, and a guard inside the fence enforces the message, grumbling answers to questions and keeping the visitor from entering any building. He also discourages workers from speaking to the stranger.

Placards express the same mood; they say in Spanish: "Danger! Danger! Danger! Don't sit on the curb. Trucks go by very fast. We are not responsible if onyone is hurt." "Don't hang around the office if you have nothing to do; go back to your bunk and rest. Others have work to do." "In the cafeteria, take your tray back to where it belongs or else you will be fired." The men around the office have got the message: with sideways glances at the office, they pass by, or grunt an answer to an inquiry. I can't remember ever being in a place where fear so visibly kept men from speaking, but this is what I imagine a police state must be like. Only at the liquor store in the nearby town is it possible to talk to the men in this camp and get an idea of what their lives are like.

Recruited in Puerto Rico, men come to Connecticut in May for a season which will last till November or December. They must come alone, leaving wives and children perhaps in nearby Hartford or Springfield, but more likely in Puerto Rico. During the season, they have only single days off; visits home are impossible. They are paid $1.75 per hour, from which about $20 are deducted weekly for room, board, and medical services. "I'd prefer to work in Puerto, Rico," one told me, "but field work pays only $1.30 there; I used to make good wages in a factory there, but there's no work there now."

Here, however, they enjoy neither contract nor job security. One man estimated that of five hundred men beginning the season, only one hundred will still be around in November; others will have been recruited to take the places of those who have left—either voluntarily, when fed up with the food or the isolation, or involuntarily, when fired. Any grievance, real or imagined, suffices for dismissal. "You can't do anything here, it's like being in jail," I was told. "Yes, like being in a jail." "If anybody talks back or complains about the food, he can be fired. Most of the time, though, you never know why somebody has been fired; the next day, the bed's just empty. People are too em-

barrassed to tell you what happened." There is no grievance procedure for the worker, needless to say; no opportunity for redress.

I did not see the camp food about which so many complained, but it's said that workers walk more than a mile to the grocery store in town to buy food, trying to make up in quality or quantity for what they are offered in camp.

The only escape from the isolation, oppressive atmosphere, and questionable food of the camp is to come to town, buy a beer, and, holding it surreptitiously in a paper bag, drink it at the side of the road. A sidewalk is the only gathering place and even there the state police last year harassed the workers so much that liquor sales fell off. Even along the roads to town, they chased the workers back up into the camp. This year there has been less harassment, but the feeling of being unwelcome still prevails.

"Can't a man relax a little after a day working in the fields?" the workers asked me. "Have a drink and a good time with his friends?" They argued, "You're from here, right? Now, if you went to Costa Rica or Venezuela, and didn't know what to do or how to behave, and without telling you anything, the police came up and started pushing you around for not acting the way they do there, that wouldn't be right, would it? Well, why don't they give us a chance?"

At a time when even the federal government is finally beginning to act to protect society's interest in the stability of the family, a work program—the only place where men can find work—which takes them away from their families for six months of the year is surely nonsense; it is also punitive and cruel. Equally cruel are the conditions which make men feel like prisoners and unwanted strangers in the country of which they are citizens.

One worker told me about the subsidies, loans, and technical assistance which he has seen given to Cuban refugees in Puerto Rico: "Why do they give them all that money," he asked, "and nothing for us?" "No, you don't understand," added his friend, another Puerto Rican. "They have been defeated, so we have to help them. It's like Korea or Vietnam, you know. When they're down, you have to give a hand."

Three times as I talked to these men I was asked whether I was from the state Department of Labor. They were disappointed when I was not. They said, "They should come and see how things are here. Not just with the boss, either; you know what people say then. Come and see how things really are. People getting fired, terrible food to eat. No rights at all. Sometime they should come here and see."

* * * * * * *

MIGRANT

Colorado Council on Migrant and Seasonal Agricultural Workers and Families

Area Code 303
892-6911

665 GRANT
DENVER, COLORADO 80203

July 30, 1970

Honorable Walter F. Mondale
Subcommittee on Migratory Labor
Old Senate Building
Washington, D.C.

Dear Sir:

Enclosed please find a study which was conducted by the Colorado Migrant Council on the nurtitional status of migrant children. Perhaps this document will provide additional information which your committee might be able use in connection with your ongoing hearings.

If we can be of further assistance, please do not hesitate to call on us.

Sincerely,

Ralph D. Martinez

Ralph D. Martinez
Deputy Director

pw
encl

NUTRITIONAL STATUS OF PRESCHOOL MEXICAN – AMERICAN MIGRANT FARM CHILDREN

H. Peter Chase, M.D.
Assistant Professor of Pediatrics
University of Colorado Medical Center
4200 E. Ninth Ave., Denver, Colo. 80220

ViJoy Kumar, M.D.
Research Fellow in Pediatrics
University of Colorado Medical Center

Janice M. Dodds, M.Ed.
Nutritionist, Instructor of Pediatrics
University of Colorado Medical Center

H. E. Souberlich, Ph.D.
Chief of Chemistry Division
U.S. Army Medical Research & Nutrition Laboratory
Fitzsimons General Hospital

Robert M. Hunter, Ph.D.
Associate Professor of Sociology
University of Colorado

Robert S. Burton, M.S.
University of Colorado

Vaughn Spalding, R.N.
Director of Migrant Health Services
Colorado Migrant Council

This work was supported by Grant # CG 8074 Emergency Food and Medical Services, Title II D, Economic Opportunity Act

ABSTRACT

The nutritional and medical problems of 300 Mexican-American preschool children of migrant workers were evaluated in the spring of 1969 in Colorado. Outstanding in the history was the high infant mortality of 63 per 1000 live births. Frequent findings on physical examination included: low height attainment, upper respiratory infections, skin infections, dental caries, enlarged livers, hypertrophied tongue papillae, and conjunctival folliculitis. Biochemical testing showed low vitamin A levels in 159 children, low alkaline phosphatase in 120 children, and low total serum proteins in 28 children. Possible methods for improving the nutrition and health of the migrant children are discussed.

Migrant farm labor is presently used in probably every state of the United States. The total number of migrant farm workers is difficult to estimate because of a lack of record keeping and the problem of definition as to who is a migrant farm laborer. In Colorado, estimates have ranged from 25,000[1] to 100,000[2] workers depending in part on whether intrastate workers crossing county lines and residents living at home and working at seasonal farm labor are included with the interstate workers. Since discontinuing the usage of alien farm workers, in which male workers from outside of the United States were transported to the United States for farm labor, there has been an increase in family travel and the resulting problems. From the view of health care it should be noted that whereas the mean number of workers per family is 3.5, the mean number of traveling family members is 6.6. The extra family members are frequently children and infants who must travel with their parents and suffer the nutritional and health consequences of travel. Little information is presently available concerning the medical and nutritional problems of these people. An earlier study described biochemical alterations in negro migrant workers in New York state[3]. A recent nutritional survey in Texas[4] probably also includes evaluation of some preschool children of Mexican-American farm workers. The purpose of the present study was to evaluate the nutritional-medical problems of the preschool children of the Mexican-American farm laborers.

METHODS

Three hundred Mexican-American children, age six years or below, were studied in May and June, 1969. Children were studied in two locations each in northeastern and southeastern Colorado. They came to the clinics voluntarily as a result of local publicity, were brought by volunteers, or were seen at one location in southeastern Colorado on the first day of a Head Start-Infant Education School program. The evaluation included medical histories, physical examinations, and blood biochemical determinations. Heights and weights were evaluated by means of the Boston Iowa Growth Grids, and head circumference on an international grid.[5] Interviews concerning food purchasing habits and cooking equipment available to the family were conducted by a

nutritionist (J.M.D.). Weekly family shopping lists were computed for approximately forty families. All laboratory tests were done on venous blood samples drawn after overnight fasting, or in a few cases, four hours after a meal. Vitamins A and C, and serum and RBC folacins were determined at Fitzsimmons General Hospital, Denver, Colorado, by methods used in the National Nutrition Survey.[6] Other biochemical determinations were done in the Colorado General Hospital Pediatric Microchemistry Laboratory.[7]

Data was analyzed (under the direction of R.S.B.) by computerized statistical methods applied to four areas of the study: sociologic data, medical history, physical examination, and laboratory tests. Two broad types of analyses were undertaken: descriptive, for summarizing the characteristics of the sample, and inferential, for finding significant relationships among these characteristics. The descriptive analysis consisted primarily of frequency distributions, comparisons with "normal" values, and determination of means and standard deviations when applicable. The inferential analyses were directed toward relating the laboratory measurements to the other data. The method used was one-way analysis of variance, with items from the sociologic data, the medical history, and the physical examination as independent variables, and laboratory measurements as dependent variables. Analyses of variances determined whether different sub-samples of subjects differed significantly with regard to their average laboratory measurements.

RESULTS

Sociologic Data

Sociologic data is available on 151 of the Mexican-American migrant families studied in May and June, 1969. One hundred and sixteen of the families gave their home base as Texas, 26 were intrastate migrants from Colorado, and the remaining families were from miscellaneous other states. All fathers were farm laborers, working a mean of 6.3 months per year in agriculture and 1.8 months per year in other occupations. Mean educational attainment for the fathers was sixth grade and for the mothers, fifth grade. The mean annual family income was $1,885, with 61% of the families having an income less than $2,500 per year and 84% with an annual income under $3,500. Twelve families (7.9%) received financial welfare assistance in some form during the previous year. In 57% of the families only Spanish was spoken; in 36% of the families, both Spanish and English were spoken by at least one of the parents; and in

7% of the families only English was spoken. These sociologic findings do not differ from those gathered on a sample of 3500 Mexican-American migrant families by the Colorado Migrant Council between 1966 and 1969. This would suggest that our sample is representative of the Colorado Migrant agricultural population.

Medical History

The mean number of pregnancies per mother was 5.7, with 29 of the 142 mothers having had more than ten pregnancies. Sixty-five of the 825 pregnancies resulted in miscarriages or still births, for a fetal wastage of 79/1000 pregnancies. Forty eight of the 760 liveborn children died within the first year of life, for an infant mortality of 63/1000 infants. Mean family size at the time of the study was 4.6 children per family.

The 300 children were equally divided between males and females in all age groups: 45 children were under one year of age, 31 were between ages one and two, 41 between two and three, 66 between three and four, 59 between four and five, and 58 were between the ages of five and six years. One third of the mothers received no prenatal care or nutritional supplements prior to delivery. Two hundred and thirty one of the 300 children were born either in the hospital or an out-patient medical clinic. Mean birth weight was 3.2 kg., with 27 children weighing less than 2500 gm at birth. One third of the mothers initiated breast feeding, and 25% were still breast feeding when the child was two months old. Supplementary vitamins were received by 10% of the children in the first six months of life. One half of the children had received no DPT or polio immunizations. Twenty-four mothers gave a history of recurrent diarrhea (more than one episode in the previous year) in their children. Ten percent of the children had never been examined by a physician while 86% of the children two years of age or older had never been seen by a dentist.

Food Purchasing Habits and Dietary Adequacy

Thirty-five families reported spending $20-$30 per week on food with five reporting higher expenditures up to $60. When the shopping lists were priced at the local markets the families were found to have consistently over-estimated the cost of their shopping lists by five to fifteen dollars. The basic weekly food supply for migrant families is reported in Table I. There

was little variation between type and quantity of food purchased regardless of family size. However, there is no way to determine individual intake from this data. From these shopping lists, which were descriptive of the family food habits, it is estimated that protein intake is adequate (vegetable proteins from beans and some animal proteins from eggs and milk). Thiamine, riboflavin, and niacin intake should be adequate also (cereals, enriched flour, and its products). Calcium and vitamin D intake are minimal to low as seen by the low consumption of milk. Iron, too, is minimal to low as a result of the insufficient intake of iron-rich foods. Vitamin A intake is almost negligable, although vitamin C intake should be adequate. When milk was available in the homes, the infants under two years of age would receive first priority with the next oldest having next priority. All of the families reported purchasing at least one third of the foods listed in Column 2, Table I in addition to the standard food supply when adequate money was available. When the additional money was available for food, the mothers reported they purchased more meat, milk, fruit, (apples, bananas, oranges), and vegetables (tomatoes, lettuce) in that order. If less money was available, these foods would be cut out in the reverse order. Candy, flavored beverages, cookies, and sweet rolls were purchased in the same amounts regardless of the money available unless the income was drastically reduced, in which case the sweet foods were eliminated from the diet.

The cooking equipment available in the homes was limited as the families carry very little with them during migration. Each baby in a family has one bottle. The family has two or three pots for cooking beans, one dish meals, or for frying; and a griddle for making tortillas on gas stoves. There is always a stove in the house with one half of these being wood stoves. Less than one-eighth of the families had running water. Pumps in the yards were the usual means of securing water.

Physical Examination Data on the 300 Children

Fifty-four of the 300 children were less than the third percentile for height, 17 were less than the third percentile for weight, and 17 less than the third percentile for head circumference. Hair dyspigmentation was noted in 21 children. Skin findings

were prominent with hyperkeratosis in 19 and skin infections in 32 children. Angular lip lesions were present in ten of the children. Eye findings were also prominent, with increased corneal vascularization in 23, dry wrinkled conjunctivae in 56, and follicultitis suggestive of trachoma in 29 children. Mucoid or purulent nasal discharge was present in 69 of the 300 children (23%). Hypertrophic tongue papillae were present in 69 (Figure 1) and atrophic tongue papillae in 36 children. Large tonsils were noted in 67 and large cervical lymph nodes in 36 children. Thirty-nine percent of all children and 58% of the children over four years of age had dental caries, with a mean of four caries per child. Upper limb muscle mass was decreased in 31 and lower limb muscle mass in 28 children. Epiphyseal wrist swelling was present in 28 children and prominent rib beading in 22 children. Livers were palpable more than two centimeters below the costal margin in the right mid nipple line in 49 of the 300 children. Skin fold measurements are shown in Table II.

Laboratory Tests

Hemoglobin and hematocrit values are compared to normal values for the state of Colorado[8] as all children had been in the state at least two weeks. These normal values are similar to those obtained in a nutritional survey of 5000 preschool children in the United States.[9] Forty-seven children had hemoglobins below the tenth percentile for age, and forty-one children had hematocrits below the tenth percentile for age (Figure 2).

Levels of serum and RBC folacin, vitamin A, and vitamin C are shown in Table III. Twenty nine children were below normal in serum folacin levels, and three children were below in RBC folacin levels. One hundred and fifty-nine children (55%) were below normal in serum vitamin A levels. Two children were low in vitamin C levels.

Laboratory results other than vitamin levels are shown in Table IV. Serum alkaline phosphatase levels were low in 120 children, blood urea nitrogens were low in 49 children, and amylase activity was reduced in 16 children. Total serum proteins were low in 28 children and serum albumin in 73 children. Serum carotene was low in 219 children. Cholesterol levels were low in 44 children and high in 28 children.

STATISTICAL CORRELATIONS

Historical-Biochemical Correlations

Children whose parents spent part of the year employed in a trade outside of farm labor had higher mean total protein values (7.2 gm%) than children whose parents worked only in farm labor throughout the year (6.6 gm%; $p < .01$). The language spoken by the parents also correlated with mean laboratory values. Children whose parents spoke only Spanish had lower total serum proteins and albumin ($p < .01$) levels than children of parents who spoke English(with or without Spanish in addition). Although not statistically significant, cholesterol and alkaline phosphatase levels also tended to be lower in children whose parents spoke only Spanish. There were no significant differences in laboratory tests done on children of the 26 families from the state of Colorado (intrastate migrants) compared to the children of interstate farm workers.

Mean vitamin levels tended to be lower in children who had weighed under 2500 gm at birth (Table V). The mean laboratory values were also significantly influenced by the total number of children in the families. Thus mean vitamin A and C levels were higher in families with fewer children, as were alkaline phosphatase and BUN values. Gamma globulins, likely an indication of the numbers of infections, were higher in families with larger numbers of children.

When vitamins were given to the mother during pregnancy or to the child in the first six months of life, the vitamin A and C levels were higher in the child (Table V). This was true for children under one year of age but was also true for the older children. Serum folacin levels were significantly higher ($p < .01$) in the children under one year of age whose mothers had received vitamins, but did not remain higher in older children. RBC folacins were also higher in children under one year of age whose mothers received vitamins or when vitamin supplements were given to the children, although the differences were not statistically significant. When vitamin C levels were analyzed on all of the children, the levels of the low birth weight children were inexplicably higher than those in the children of higher birth weight. Vitamin levels and other lab tests did not differ significantly between bottle fed and breast fed infants under one year of age. A history of greater incidence of having had measles was

found for children with low vitamin A levels (36 of 126) than in children with normal vitamin A levels (18 of 120).

Physical Examination - Biochemical Correlations

In the physical examination, low vitamin A levels correlated statistically ($p < .05$) with a greater incidence of: 1) skin infections, 2) reduced upper and lower extremity muscle mass, 3) nasal discharge, and 4) hypertrophied or atrophied tongue papillae compared to children with normal vitamin A levels. There was no correlation between low vitamin A levels and corneal dryness, hypervascularity, dyspigmentation, or wrinkling on the physical examination. Skin fold thicknesses tended to be lower for children with low vitamin A levels than for children with normal levels. The mean lateral thoracic, subscapular, and triceps skinfolds measured 5.1, 5.5, and 7.8 respectively for children with low vitamin A levels, compared to 5.7, 6.1, and 8.3 respectively for children with normal vitamin A levels.

Mean laboratory values were determined for the presence or absence of each of the physical examination findings. Table VI shows the mean laboratory values in children with or without various abnormalities on the physical examination. When a trend appeared, values are included even though statistical analysis did not prove a difference. Vitamin A values were significantly lower ($p < .05$) in children with hair dyspigmentation, skin infections, and abnormal tongue papillae. Serum folacins and gamma globulin levels were both significantly lower ($p < .01$) in children with large livers. Mean vitamin C and alkaline phosphatase values were significantly lower in children with low height.

DISCUSSION

The general lack of medical care prior to and following delivery is reflected in the high mortality rate in the first year of life. In this study, the Mexican-American migrant infant mortality was found to be 63 per 1000 live births. The 1968 infant mortality for low income areas served by the Neighborhood Health Centers and the City Hospital in Denver was 23.4 per 1000 live

births.[10] This was greatly reduced from the 1964 Denver figure of 33.1 per 1000 live births taken prior to the onset of the neighborhood health program in 1965. The migrant neonatal mortality figure of 63 deaths per 1000 live births is comparable to a similar figure for the overall United States in the year 1930. The high infant mortality may, in part, be due to the lack of of hospital delivery of newborn infants, most of whom would be considered "high risk" because of the lack of prenatal care, the poor housing and sanitation, inadequate nutrition, and the need to travel with a small infant. It is conceivable that rural neighborhood health programs, as recently proposed for migrant health care, could greatly reduce the neonatal mortality in this population. A program for hospital care will also be necessary, however. Migrant families do not qualify for Medicaid benefits in most states because they must first qualify for some program of categorical assistance. These commonly include Aid to Dependent Children and programs to assist the blind, disabled, and aged. Rarely do migrating Mexican-American families lack a father, and he is usually employed. Few, if any, migrants are blind, disabled, or aged. Thus, while residency has been eliminated as a requirement for Medicaid, it has been of little use to the migrant.

The incidence of low serum vitamin A levels in these United States children was higher than that found in ten of eleven underdeveloped countries in the Far East, Central America, and South America studied over the past ten years.[11] This high incidence of vitamin A deficiency was anticipated from the lack of foods containing vitamin A in the basic food list reported in Table I. Egg yolks are the main, and frequently the only, source of vitamin A. Some families pick carrots in Texas for approximately two weeks in March and bring these home for meals or for trade with other families. However, the use of mechanical harvesters of carrots and of Mexican National farm workers on a daily basis have decreased the amount available for consumption by families or farm workers in Texas. It is also true that carrots are not a popular food in the diet of the Mexican-American culture, and nutrition-education programs may be one way of approaching the deficiencies.

With one third of the mothers receiving no prenatal care or nutritional supplementation and a much higher percentage receiving inadequate nutritional care, it is likely that vitamin A deficiency is present from birth in many of the infants. Mothers of deficient infants had a greater number of pregnancies than mothers of children with normal vitamin A

levels. It is likely that the greater number of pregnancies, with greater maternal depletion of vitamin levels, as well as the larger number of siblings to divide the food amongst, were both important factors in the lower vitamin levels of these children. Low vitamin A values were more apt to be found in infants whose mothers did not receive nutritional supplements during pregnancy. Improved prenatal care would help the nutritional status of the offspring and would probably reduce the infant mortality.

The low vitamin A levels correlated statistically with an increased incidence of skin infections and upper respiratory tract infections on physical examination. Changes in the tongue papillae appeared to be a reliable physical sign of low serum vitamin A levels in this group (Figure 1) whereas dryness and wrinkling of the cornea and increased corneal vascularization did not show any statistical correlation. Dark adaption was not evaluated, but is known to be associated with vitamin A deficiency. Xerophthalmia was not detected in any of these children. An increased incidence of measles was found in the medical history amongst children with low vitamin A levels suggesting that improvement of nutritional status may reduce the incidence of measles. In undernourished populations, measles is known to be associated with a high mortality rate. The elevated gamma globulin levels in children with low vitamin A levels likely reflect the increased number of infections. Improvement of nutritional status would likely improve both the morbidity for infections and the mortality rate in these children. The time necessary to improve serum vitamin A levels is apparently quite long. We restudied nineteen children with low vitamin A levels after a minimum of 28 days in Infant Education - Head Start over a six week period. They received two meals and two snacks per day in the school and oral vitamin drops from the school nurse. In spite of this supplementation, serum levels were still low upon re-evaluation. It is known that liver stores must be replenished first in vitamin A deficiency, and it is likely that this is what was happening in these children. It was not appropriate to obtain liver biopsies to more accurately assess the degree of vitamin A deficiency.

The majority of the families had come recently from Texas where fresh grapefruit and oranges had been readily available. It was therefore not surprising that vitamin C levels were quite normal. Potatoes are also a staple of the diet and, when eaten in large quantities, can meet vitamin C requirements. It was of interest, however, that vitamin C values tended to be lower in children with low vitamin A levels, and that vitamin C levels were significaltly lower in the 59 children with low height. It is possible that the physical examination findings of the rib beading and epiphyseal swelling were related to vitamin D deficiency at another time in the year. Very few high alkaline

phosphatase values were found, suggesting that active rickets was not the cause of these findings. It was striking that the children with physical signs of vitamin D deficiency were the same children who gave a history of not liking milk. This was a similar finding in other children showing clinical signs of poor nutritional status, in that they frequently disliked one of the staples in the families' diets. Because of economic limitations, the families were not able to make alterations in the food regularly purchased to meet idiosyncracies of one child's likes or dislikes. A greater number of children had lower serum folacins than RBC folacin levels. It is thought that the former represents recent intake, whereas the latter represents long term accumulation. This would suggest poorer nutritional intake while in the migrant stream than when at home. However, the serum and RBC folacins correlated significantly ($p < .01$) in all age groups. This is suggestive that current normal values for one of these tests may be inaccurate.

In the present study, children tended to have adequate subcutaneous fat, but to have a frequent incidence of low height attainment. When Mexican children come from upper economic class families in Mexico City, height attainment is similar to the Iowa Growth Grids used in this study.[12] It appears likely that the low height attainment in our children was the result of generalized undernutrition, including protein and vitamins, rather than being on a genetic basis. The decreased stature may also be related to poor prenatal nutrition. Using a recent classification of kwashiorkor[13], one of our children had serum proteins below 5.5 gm% and was below the third percentile for height, and would be classified as having kwashiorkor. At least two additional children would have been classified as having generalized caloric deficiency or marasmus.

Cholesterol levels were above normal in 28 of the 300 children (9.3%). This may be related to the common use of animal fats in cooking. As it is the current belief that cholesterol deposits start in childhood, it is possible that this malnutrition is as dangerous as some of the deficiencies. Information concerning the mean age and the incidence of coronary artery disease would be of interest in the adult Mexican-American population.

Folliculitis suggestive of trachoma was an unexpected finding in ten percent of these children. The presence of trachoma was verified by Giemsa and fluorescent antibody staining, and is being described in detail in a separate report. Trachoma is usually a serious disease in children, although some children did show evidence of secondary infections. Trachoma is a major cause of blindness in underdeveloped countries, and one father was coincidentally seen who was apparently losing his vision from complications of trachoma. Four of his five children were also infected.

There did not appear to be a single laboratory test that best reflected nutritional status in these children. Low alkaline phosphatase values were found in 120 of the 300 children, and correlated statistically with low height attainment. Because of the lack of normal values for laboratory tests in children of different ages and cultures, it was important to compare mean laboratory values for children with and without abnormal physical examination findings (Table VI). Determining the mean and range of values for children without abnormal physical findings might be a better way to determine the normal values for a group than is the present method of doing two standard deviations for the mean value of a population studied. Unfortunately, multiple laboratory findings had a tendency to be lower (Table VI) in the presence of abnormal physical exam findings, and it is often difficult to associate an abnormal finding with any specific laboratory test.

The children's mean serum protein levels were significantly higher when the fathers had additional employment outside of summer farm labor. The children's mean serum proteins were also significantly lower when the parents did not speak English. The ability to speak and read the English language allows the migrant people to communicate with employers, to read labels on commodity foods, to communicate with health and social personnel who might be able to help them to learn about community benefits available, and to help their children with the language that must be spoken in the schools. As 57% of the parents do not speak English, adult education classes for teaching English would be a way in which these families might be helped.

The mean income of the migrant families in this study was $1885.00 per year, with 60% earning less than $2500.00 per year. Yet only twelve families reported having received welfare assistance in the previous year. Money is not available for

adequate health care or nutrition. Travel is necessary for migrant farm workers in order to find work, and is an additional expense to the family. Travel perpetuates low educational attainment, as children are removed from schools and return late. It is not unusual for home base schools to penalize the children for their absence by reduction in grades, regardless of the ability of the children. A positive aspect of present migrant programs is the attempt being made to furnish summer schools in the areas of travel for the migrant children.

Winter employment in Texas is often difficult to find. Agriculture is the major industry in southern Texas, where many of the Colorado migrants come from, and inexpensive farm labor can still be hired on a daily basis from Mexico. The Mexican National who enters the United States illegally for long term work is also still a problem in Colorado. They keep the pay low and take jobs from the United States residents. The illegal entrants are unable to complain to authorities when someone decides not to pay them, or when they are given substandard housing as they know they would then be caught and returned to Mexico. At present there is no penalty for farmers hiring illegitimate labor and this might be considered.

At present many existing programs are unable to be utilized by the migrant population. Inclusion of the migrant population in the medicare-medicaid hospitalization programs without first meeting each county's welfare certification practices would be of great benefit. Migrants do not presently qualify for food stamps while traveling because of unequal earnings throughout the year. Recommendations made at the White House Conference on Nutrition for food stamp certification once yearly and applicable from state to state would be helpful but this has not yet been acted upon. Commodity foods have been of little help because of limited items and pride, with a frequent history given for having been told "you are strong and able to work, so don't come back here again." An additional problem concerning commodity foods is the storage of approximately thirty pounds of food per person (frequently distributed on a monthly basis) in a one or two room dwelling. Lack of room, refrigeration, and protection from rodents and insects would probably interfere with utilization of commodity foods if they were readily available.

A possible solution to the problem of communication between migrants and existing health and welfare facilities is the introduction of migrant health aids into the migrant stream as is currently being tried on an experimental basis by the Colorado Migrant Council. With the alteration of existing program policies to accommodate migrants, and the use of health aids to make the programs known to the people, the health and nutritional status of the migrants could greatly improve. Long term objectives of finding suitable jobs and living conditions outside of the migrant stream will be necessary. Adequate nutrition, health care, education, and housing should receive high priority in the present needs of the migrant farm worker and his family.

84-853 O - 72 - 14

TABLE I

PRIMARY FOODS IN THE COLORADO MIGRANT FARM WORKERS' DIET

BASIC FOOD ITEMS	ADDITIONAL FOODS	LESSER USED ADDITIONAL FOODS
Potatoes	Chuck roast	Pork roast
Eggs	Ribs	Pork chops
Wheat Flour	Cabbage	Variety meats
Hamburger	Carrots	Cookies
Chicken	Canned corn	Oatmeal
Dry cereal	Bananas - in season	Saltine Crackers
Pinto beans	Apples - in season	Bread
Rice	Oranges - in season	Ice cream
Macaroni	Milk	Sugar
Lettuce	Bottled soft drinks	Candy (Hard)
Tomatoes	Canned Chili (no meat)	Potato chips
Lard	Canned spaghetti	Corn Chips
Kool-Aid	Sweet bread (rolls)	Apple juice
	Corn flour	Pineapple juice
		Orange juice

TABLE II

SUBCUTANEOUS SKIN FOLD MEASUREMENTS*

	<7.5 mm	<5 mm	<3 mm
Lateral thoracic	238	139	11
Subscapular	235	99	2
Triceps	126	15	0

* Values represent the number of children falling into each group as measured with standard techniques[14] using the Lange Skin Fold Calipers.[15]

TABLE III

VITAMIN LEVELS *

	Less Than Acceptable		Acceptable
	Deficient	Low	
Serum folacin (ng/ml)	4 (<3)	25 (3.0-5.9)	264 (≥6.0)
RBC folacin (ng/ml)	2(<140)	1(140-159)	285 (≥160)
Vitamin A (μg/100 ml)	9(<10)	150+(10.0-29.9)	129 (≥30 or >20 if < 6 mos old)
Vitamin C (mg/100 ml)	0 (<0.1)	2(0.1-0.19)	280 (≥0.2)

* Values represent the number of children in each category with the laboratory values shown in parentheses being of the National Nutrition Survey.[6]

+ Age corrections are included, so that children under 6 months of age are not included unless the value was less than 20 μg/100 ml.

TABLE IV

LABORATORY RESULTS FROM THE PRESCHOOL CHILDREN OF MIGRANT WORKERS

	LOW	NORMAL	HIGH
Alkaline Phosphatase (International Units)	120 (<50)	171(50-150)	4(>150)
Blood Urea Nitrogen (mg/100 ml)	49 (<10 from 2-6 yrs) (<5 from 0-2 yrs)	240 (10-20 from 2-6 yrs) (5-15 from 0-2 yrs)	2(>20)
Cholesterol (mg/100ml)	44(<140 if >1 yr) (<70 if <1 yr)	216(140-240 from 1-6 yrs) (70-170 if <1 yr)	28(>240 if 1-6 yrs) (>170 if >1 yr)
Amylase (Close-Street Units/100 ml)	16 (<6)	264 (6-33)	1(>33)
Total Serum Proteins (gm/100 ml)	28(<5.0 if < 6 mos) (<5.5 from 6 mo-1 yr), (<6.0 if >1 yr)	251(5.0-8 if < 6 mos) (5.5-8 if 6 mo-1 yr) (6-8 if >1 yr)	5 (>8)
Serum Albumin (gm/100ml)	73(<3.5 if <1 yr) (<3.8 if >1 yr)	208(3.5-5.5 if <1 yr) (3.8-5.5 if >1yr)	1 (>5.5)
Serum Globulins (gm/100 ml)	α_1 26 (<0.15)	245(0.15-0.44)	10 (>0.45)
	α_2 1(<0.34)	266(0.35-0.94)	4 (>0.94)
	β 1(<0.44)	260 (0.45-0.94)	4(>0.94)
	γ 6 (<0.44)	216 (0.45-1.2)	60 (>1.2)
Serum Carotene (µg/100 ml)	219(<100)	46 (100-150)	9(>150)

Values represent the number of children below, within, or above two standard deviations of normal. Normal values or their limits are included in parentheses.

TABLE V

MEAN LABORATORY VALUES CORRELATED WITH MEDICAL HISTORIES +

1) Birth Weight	<2500 gms.	2500-3500 gms.
Serum Folacin:		
Children < 1 yr old	6.7	8.3
All Children	8.8	10.2
RBC Folacin:		
Children < 1 yr old	292	364
All Children	362	406
Vitamin C:		
Children < 1 yr old	.73	1.14
All Children	1.07	.82
Gamma Globulin:		
Children < 1 yr old	.85	.9*
All Children	.91	1.03*
Amylase:		
Children < 1 yr old	6.0	11.2*
All Children	11.7*	13.7*

2) Number of Living Children	1 or 2	3 to 9	9 to 20
Vitamin A	32**	28	26
Vitamin C	.92	.81	.74
Alkaline Phosphatase	58**	50	52
Gamma Globulin	.83**	1.06	1.06
BUN	13.7	12.1	11.1**

3. History of Measles	Yes	No
Vitamin A	26	30*

4) Nutritional Supplements During Pregnancy	Yes	No
Vitamin A:		
Children < 1yr old	36	30
All Children	30	26**
Vitamin C:		
Children < 1 yr old	1.0	0.62
All Children	.86	.68**
Serum Folacin:		
Children < 1 yr old	8.92	6.66*
All Children	10.12	10.11
RBC Folacin:		
Children < 1 yr old	367	358
All Children	397	393

5) Nutritional Supplements to Child in first 6 months	Yes	No
Vitamin A:		
Children < 1 yr old	39	32
All Children	31	28
Vitamin C:		
Children < 1 yr old	.72	.86
All Children	.87	.75**
Serum Folacin:		
Children < 1 yr old	8.88	8.09
All Children	10.2	10.2
RBC Folacin:		
Children < 1 yr old	436	328
All Children	405	379

+ The figures in this table represent the mean laboratory values for each of the given categories. For the category "Number of Living Children", the asterik is placed by the value which is significantly different from the other two values.

* $p < .05$
** $p < .01$

TABLE VI

MEAN LABORATORY VALUES CORRELATED WITH PHYSICAL EXAM FINDINGS +

	Absent	Present
1) Hair Dyspigmentation		
Hemoglobin	12.7	11.6
Serum Folacin	10.6	9.6
RBC Folacin	40.7	33.5
Vitamin A	28.9	18.0*
Vitamin C	0.85	0.58
Alkaline Phosphate	57.6	47.2
Cholesterol	167	157
Carotene	69.7	46.8**
Tyrosine	4.9	2.9
2) Skin Infection		
Vitamin A	29.1	25.3*
Vitamin C	0.86	0.79
Tyrosine	6.6	4.6
3) Reduced Muscle Mass (lower limb)		
Serum Folacin	11.7	10.4
Vitamin C	0.85	0.77
Phenylalanine	3.3	2.9*
Tyrosine	4.9	3.9
Alkaline phosphatase	55.2	73.0*
4) Enlarged Liver		
Serum Folacin	10.8	9.1*
RBC Folacin	407	391
Vitamin A	28.9	26.8
Vitamin C	0.85	0.80
Gamma Globulin	1.04	0.92*

	Absent	Present
5) Lip Lesions		
Serum Folacin	10.6	9.1*
Vitamin C	407	391
Albumen	4.06	3.74*
Phenylalanine	4.8	3.6
6) Abnormal Tongue, Papillae		
Vitamin A	29.3	25.5*
Gamma Globulin	0.99	1.11*
Tyrosine	4.95	3.55

7) Height	<3rd%	3-50%	>50%
Serum Folacin	9.8	10.1	10.7
RBC Folacin	385	399	414
Vitamin C	0.70	0.83	0.94*
Alkaline Phosphatase	53.2	52.0	69.8**
8) Weight			
Hematocrit	38.7	37.9	37.4
RBC Folacin	383	394	411
Vitamin A	31.4	29.4	27.8
Vitamin C	0.73	0.83	0.84
Albumen	4.16	4.13	3.96*
βGlobulin	0.57*	0.62	0.65
Amylase	10.7*	14.1	13.2
9) Head Circumference			
Vitamin C	0.76	0.85	0.83
Alkaline Phosphatase	55.2	53.6	67.4*
Tyrosine	3.8	5.0	5.0

+ The number of children with each of the positive findings is given under "Physical Examination" in Results. The figures of 1-6 represent the mean laboratory values for children with or without the abnormal findings. For height, weight, and head circumference, the figures represent the mean laboratory values for the children in different percentiles of growth; the figure with the * is then significantly different from the other two figures at the levels of significance indicated.

* $P < .05$

** $p < .01$

REFERENCES

1. Colorado Department of Health: Annual Progress Report - State Migrant Health Program, MG09F (69) June 1968-June 1969 - Publication # SH-DH(M) - 53 (6-69-2).

2. Survey provided by Colorado Migrant Council in 1969, estimated from one day census taken in the summer of 1969.

3. Thiele, V.F., Brin, M., Dibble, M.V.: Preliminary biochemical findings in negro migrant workers at King Ferry, New York, Amer. J. of Clin. Nutr. 21: 1229, 1968.

4. McGonity, William J.: Nutrition survey in Texas, Texas Medicine 65: 40, 1969.

5. Nellhaus, G.: Head circumference from birth to 18 years: practical composite of international and interracial graphs. Pediatrics 41: 106, 1968.

6. O'Neal, R.M., Johnson, O.C., and Schaefer, A.E.: Guidelines for classification and interpretation of group blood and urine data collected as part of the National Nutrition Survey, Pediat. Res. 4: 103, 1970.

7. O'Brien, D., Ibbott, F.A., and Rodgersen, D.O.: Laboratory Manual of Pediatric Micro-Biochemical Techniques, New York, 1968, Harper & Row Publishers.

8. McCommon, R.W.: Human Growth and Development, Illinois, 1970, Charles C. Thomas Publisher.

9. Owen, G.M., Nelsen, C.E., and Garry, P.J.: Nutritional Status of preschool children: hemoglobin, hematocrit, and plasma iron values, J. Pediat. 76: 761, 1970.

10. Chabot, Andre: Decreased infant mortality rate in a low income population, American Pediatric Society Abstracts, Second Plenary Session, 5, 1970.

11. Hearings before the select committee on nutrition and human needs. Part 3, Washington, D.C., 1969, United States Government Printing Office, 751.

12. Croviato, J.: Personal Communication. Hospital Infantile de Mexico, Mexico City.

13. Van Duzen, J., Carter, J.P., Secondi, J., and Federspiel, C.: Protein and calorie malnutrition among preschool Navajo Indian children, Amer. J. Clin. Nutrition 22: 1362, 1969.

14. Tanner, J.M. and R.H. Whitehouse: Standards for subcutaneous fat in British children, British Medical Journal 1: 446, 1962.

15. Lange Skin Fold Caliper, Manufactured by Cambridge Scientific Ind. Cambridge, Maryland.

Appreciation is expressed to Mrs. Carol Dabiere, Mrs. Josie Fetters, and Miss Noreen Welch for their assistance in obtaining laboratory values, to Mrs. Yaye Herman, Mr. Wayne Goad, and Dr. Nicholas Raica of Fitzsimons Nutritian Laboratories for analyses of Folic Acid, Vitamin C levels, and Vitamin A levels respectively.

Correlations Between Biochemical Tests

Laboratory values were correlated with each other by age groups; group I, 1-11 months; group II, 12-23 months; group III, 24-35 months; group IV, 36-47 months, and group V, 48 months and above (only values of statistical significance of $p < .05$ are reported). Hemoglobin correlated with hematocrits in all age groups ($p < .01$) and with cholesterol levels in groups I, III, and V. Carotenes were lower in children with lower hemoglobins in groups III and V. Serum folacins correlated significantly ($p < .01$) with RBC folacins in all age groups. Vitamin A levels correlated significantly ($p < .02$ or less) with Vitamin C levels in four of the five age groups; I, II, III, and V. Gamma globulin levels correlated negatively with the vitamin A levels (i.e., higher levels of gamma globulin in the presence of lower vitamin A levels). Low phenylalanine levels correlated positively with low tyrosine and low BUN levels in group I, low BUN levels in group III, and low tyrosine levels in group V. Total serum proteins correlated with all of the protein components except α_1 proteins for all of the age groups. Total proteins correlated with serum cholesterol levels in groups I, II, and IV. Children with low serum proteins had a mean phenylalanine-tyrosine ratio of .83, and children with normal serum proteins were found to have a ratio of 1.24 ($p < .01$). Amylase and cholesterol values correlated with each other in groups I and IV,

* * * * * * *

Supplemental Statement of Roger McClure Dunwell, Member, Bar of the State of New York

INTRODUCTION

My name is Roger McClure Dunwell. I am a member of the Bar of the State of New York. For the last almost eleven months I have been working with the United Farm Workers Organizing Committee and Colonias del Valle, Inc. in the lower Rio Grande Valley of Texas, particularly in Hidalgo County.

The testimony I have been asked to present comes from our experiences in the Valley. Much of what follows is dry figures, descriptions of labyrinthian governmental attempts to deal with poverty, disease, or exploitation and their consequent failures. Implicit in the numbers, the programs, the explanations, the shameful history of private and public neglect is something, someone, very human, a tiny baby already crippled for life from polio, a young boy going blind, a worker poisoned by pesticides, an old man twisted with arthritis for whom no welfare program exists. The story is more than one of human disease, it is fundamentally one of a diseased society, which has grown by devouring the spirit and health of the Chicano, and given nothing in return.

My testimony is a product of the efforts of many people; my colleagues at the United Farm Workers, Colonias del Valle, and the National Farm Workers Service Center, the staff of *¡ Ya Mero !*, a local Spanish-language newspaper, and Mr. David Leonard, of the Field Foundation, whose assistance in research and preparation were invaluable. I need hardly add that any errors or omissions are entirely my own.

PROFILE OF HIDALGO COUNTY AND THE FARMWORKER POPULATION

Hidalgo County lies in the southernmost reaches of the continental United States, across the Rio Grande from Mexico. Travelling along the rectilinear farm roads south towards the river, one sees the great expanses of cattle ranches, among them a portion of the King Ranch, giving way to the softer, seemingly more yielding semi-tropical farming and citrus lands on which the majority of the farmworkers are employed. To the West, towards Starr County, rolling desert terrain appears, where the moist Gulf easterlies have become dry and scalding like the breath from a blast furnace.

With its climate, which, except for a few chilly months in winter, is stiflingly hot, one would expect that Hidalgo County would be a sleepy, though prosperous county (for there is oil, in addition to the rich soil). In fact, the county can boast of few who are truly prosperous. The majority of the population lives in abject poverty. As for sleep, the county has never been quiet. Once the scene of bloody border wars, and genocidal massacres of Mexicans, it is now the battlefield in a struggle between the few who have and the many who have not. In 1967 Texas Rangers poured into Hidalgo and Starr counties to crush a strike of melon pickers. Today those workers, and thousands like them, are organizing again, and waiting.

Hidalgo County has about 200,000 residents, (the exact number is currently a subject of some dispute between local mayors and the Bureau of the Census). Approximately 30% of the population is "Anglo", that is, of any extraction but Mexican or black. The attitudes of this distinct minority are faithfully reflected in McAllen's *Monitor*, one of several Valley dailies owned by R. C. Hoiles of Santa Ana, California, whose Freedom editorials promote the doctrine that solely by self-responsibility is any good produced and, accordingly, that not only all welfare measures, but even public education and taxation are corrupting. Great wealth, as a correlary, should be a virtue.

Belying the county's poverty, Hidalgo had Texas' largest crop income in 1960, close to $51 million. About 100,000 acres of vegetables are harvested annually, with 65,000 acres in citrus, and 135,000 in cotton (1964–1965 *Texas Almanac*). Nearly all the large farms are owned by Anglos. [See Appendix A]

It is the Chicanos, numbering over 130,000, who work the fields and pick the crops. Living in small colonias, unincorporated settlements which usually have no drinking water, never have sewage systems, in many instances no electricity or telephones, or living in the urban barrios, they are desperately poor. 54% of Spanish-surname families have incomes less than $3000, according to a study made at Texas A&M in October, 1965. A study made at Texas A&M a year later revealed that half the Spanish-surname families had incomes under $2000 per year. [See Appendix B for comparative figures from O.E.O.]

The median family income for Spanish-surname persons in the McAllen area, which is relatively developed, was $2027, (less than half of the U.S. or Texas populations), according to the 1960 census, and there is little reason to suspect that figure has risen significantly. Median school years completed were 3.3., compared with 10.6 nationally and 10.4 for Texas. Standard Metropolitan Statistical Area figures rank three Hidalgo cities, McAllen, Pharr and the county seat, Edinburg, as among those with the lowest income in the nation.

Hidalgo ranks first in the nation in the number of resident migrants, estimated to be about 37,500. Adjacent counties, Wallacy, Starr and Cameron, contain about 50,000 more. I recall looking at a Department of Labor map showing patterns of migration. Lines of migration like saplings rose from California and Florida. Out of South Texas grew a huge tree, stretching its limbs into virtually every major agricultural area in the United States. The migrants may begin leaving the Valley as early as April depending on the work available. By late June, all have left for the North. They will return to their homes from September to November, after the harvests. If they are lucky, work will be available in the citrus groves, or in truck crops—predominantly cabbages, onions, carrots. Later, in the Spring, there is a short, intense harvest of melons and tomatoes. But for many, there is no work. Long lines form outside employment commission offices, and the shape-up stations at the bridge. Unemployment in all occupations reaches 6.8% during November; it never falls much below 6% in any month. It is difficult to ascertain what the unemployment in agriculture may be at any given time. An official at the Texas Employment Commission told me that it might be as high as 10% in December. Actually, the number of persons unable to find full-time employment in agriculture during the winter is probably much higher than ten percent.

The oversupply of farm labor, the reasons for which are discussed more fully below, have resulted in a disastrously low wage scale. A dish washer in a cafe complained to me once that he had been cheated. His employer owed him $15 for working a fifty hour-week. The dish washer had received only $12. Gas station attendants may earn well under $1/hour. The average hourly wage in agriculture, despite the federal minimum wage of $1.30, and the new Texas minimum wage pegged twenty cents below (and which does not yet cover piece work), amounts to 98¢/hour. The farm worker may earn as little as $922 for eighty-five days of employment during the year.

The migrant's life expectancy is an unsurprising forty-nine years. Infant mortality is 125% above the national rate, as is maternal mortality. Influenza and pneumonia are 200% above the national rate, tuberculosis and other infectious diseases 250%. Accidents are 300% above the national rate.

In a sense, wage data and disease and accident figures tell the whole story. A handful of people are extremely wealthy, the majority paupers. It is the few who are wealthy who employ the poor. The wealth is simply not being distributed fairly. Concomitantly, the exploited fall victims to the age-old negative feedback system of poverty. Without money, you cannot buy sufficient food, cannot get drinking water, cannot build sewages systems, cannot see a doctor for checkups. Illness and accidents follow inevitably. One has no money to see a doctor, disease becomes chronic, the body dies.

A variety of governmental programs, federal, state, county and municipal, have been devised to meet the needs of the poor. The doctors have already told in chastening detail of their failure. A review of the programs themselves, and of the economic and political milieu in which they operate, explains why.

GOVERNMENTAL RESPONSES TO THE CRISIS IN HEALTH

At first, the variety of health services available through governmental agencies would seem paradoxical; demonstrably egregious health conditions exist in a county which is serviced by Social Security, federal-state categorical assistance and Medicaid, county-state programs, a Migrant Health program, an OEO emergency food and health program, a county welfare program, and city hospitals. Because the Social Security programs are uniquely standard in the operation and eligibility, it is the remaining programs which I would like to review. Social Security will be discussed later, in an analysis of legislation and public responsibility.

The Texas State Department of Public Welfare is directed in the county by Mr. James Covey. If a person in need turns here for help he will encounter a pleasant, concerned and knowledgeable staff. If his situation happens to fit within the three protective services, children, adoption studies or assistance, he may receive aid.

But in Texas aid is limited to four categories: old age, aid to the blind, aid to the permanently and totally disabled, or aid to families with dependent children. There is no general assistance, as in California. Also in Texas welfare payments are limited by the constitution to a ceiling. Even if the four categories are broadly construed, the percentage of the Valley poor who are eligible is very small. Many otherwise eligible indigents are resident aliens, who, though they may have lived in the Valley for many years, are still ineligible for lack of citizenship, the requirements for which include a working knowledge of English. Citizens children are eligible for AFDC, and certain aliens may receive OAA. The poor with few exceptions are excluded. In 1968, only 5225 children in 1607 families received AFDC; 4715 elderly persons received OAA: 98 received Aid to the Blind; 276 received APTD. Many more children need AFDC, but are barred by statutory requirements. Because relatively few elderly are eligible for Social Security retirement benefits, OAA, the obvious alternative, should similarly be much expanded. APTD represents only a fraction of the thousands of persons who are disabled, but barred by rigid statutory requirements or lack of citizenship.

Mr. Covy has privately deplored the state system of welfare, but says he is obliged to administer it the way the people of the state directed through their elected representatives. The county has seven branch offices located in the main cities; if people call in a social worker will be sent out. But Mr. Covey complained that because the salaries are low ($5100–8000), his agency has great difficulty in retaining social workers, many of whom move into teaching positions because the salary is better and extensive travelling not required. Hidalgo County has sixty-five positions, but twenty-eight vacancies. He defended women on AFDC as responsible. The average tenure is eighteen months. Most have good credit ratings. When asked what he deemed to be the most critical problem in the county, he replied: "Lack of continuous, stable employment, due to lack of industry. Money gives status and power. You cannot cover the waterfront with categorical assistance."

For those eligible, Medicaid is clearly a valuable medical resource. Unfortunately, it can take more than a month to receive a Medicaid card. I visited a man who had just lost a leg in a field accident. He had been waiting almost two months to be medically certified by the state for AFDC, and would have waited much longer for certification and a card. Our office called the state office in Austin. They had misplaced his file.

Dr. John Copenhaver administers and directs the County Health Department. (An organization chart of the County Health Department is included as Appendix C.) His office coordinates a variety of preventative, curative and diagnostic services, including city clinics. His office also administers migrant health funds.

An interviewer found him to be:

"An elderly, personable gentleman, near retirement who spelled out in considerable detail the county's acute health needs. He made no effort to conceal the serious deficiencies in all the programs. In every instance the immediate cause was lack of funds to make the programs more than token; but the underlying cause, he stated very bluntly, was the local political situation where those in office reflect the dominant economic interests. To public officials, the County Commissioners and the judge, health is a very low priority. The county hospital was closed down because 'it lost money.' The worst problem here is the doctors and the medical association. The state will not approve programs until the County Medical Association pushes for it.' Every program needs more funding, more personnel. 'But human needs are subordinate to political and economic interests.' 'I do not know how to obtain more money. You need a professional advocate.' 'What we need most in the valley is population control. Next, seeing to it that the really sick receive treatment. We need a clinic for the poor.'

"Migrant Health funds for the county were $185,000 for fiscal '69. $139,000 is added as local matching funds. But this figure is obtained by adding local salaries and operating outlays, and so does not represent additional appropriations by the state or county. The money is spent primarily for hospitalization for migrants, then outpatient fee for service, since the latter is deemed the most important. The Health Department has 3 Sanitarians whose job it is to give people advice on sanitary procedures, water supply, housing, rodent control. But they are grossly overburdened and 'don't get below the surface.' There is one health educator for three counties. 'The non-migrant farmworker is out of luck here, he receives no aid until near starvation. The only salvation is to train these people for industry and to have fewer children.' Dr. Copenhaver is aware of many pressing needs, but feels officials do not understand public health needs. Health

gives the County Commissioners less trouble and so receives less money. Only emergency situations get attention.'"

Lack of money and support from county officials is not, however, the whole story. It is true the 1970 county appropriation is only $170,881, and that the department asked $18,000 more, that expenditures run only slightly above county expenditures for their jail and correctional facilities. It is also true that there is a real failure within the department itself. Though Dr. Copenhaver is by no means solely responsible for County Health's failure, a statement he recently made is instructive.

Hidalgo County has been suffering a polio epidemic. Fourteen children have been struck by the disease, all but one under the age of two. Three have died. Commenting on the epidemic, Copenhaver said:

"'Polio is still around because of apathy . . . *I don't think financial status has anything to do with polio*', except for the lack of money to pay for regular visits to a pediatrician. . . 'The sanitary conditions or closeness of individuals might be involved.'" *Valley Morning Star*, July 12, 1970, attached as Appendix D. (emphasis added)

Equally unsettling examples of the attitude prevailing in the department, and the failure of initiative come to mind. Until an N.B.C. film crew came to document the Field survey team's work in the Weslaco labor camp, which is operated by the county, there had been no visits by a public health nurse. Following the attending publicity on the evening news, a nurse made an appearance. In passing, I should mention that conditions in that labor camp, though not the worst in the county, are terrible. There is no interior plumbing. Drinking water comes from public spigots sometimes over one hundred feet away. Communal toilets are similarly located. Overcrowding, perhaps what Dr. Copenhaver had in mind, and deteriorating "apartments" are the order of the day. Some new housing has been added, but it is beyond the reach of most of those who have been forced into the migrant camp.

Another example of the gaps in the county's program is a child who came into our office covered with sores. He had missed the dermatology clinic by two days, and would have to wait twenty-eight days for the next.

The Department is, of course, overworked. Mrs. Ruth McDonald, the dedicated Director of Public Nursing, commented in an interview:

"We have seventeen Registered Nurses and eight Licensed Vocational Nurses, or twenty-five for this population of nearly 100,000. We do only a skimming job. Time and pressure oblige the nurses to make referrals, and that is the end of it. Most of our work is with the migrants, but we are out of money for the year by March 1st., for drugs and hospitalization. We have a Pre-Natal Clinic, but have to limit the number to twelve a week. The doctor spends two hours a week for the clinic. We cannot do follow-up because the number needing service is so great and our staff so limited. The USDA Supplemental Food Program is predicated on need, which means a visit by a public health nurse. We have no social workers. We try to coordinate our Family Planning with OEO Planned Parenthood, but there is inevitable fragmentation."

Mrs. McDonald's critique, like Dr. Copenhaver's emphasis on a lack of funding, is well taken. Still, as examples show, people continue to slip through the interstices of a system which should be coping with their needs. Finally, the failure of the County Health Program comes down to a lack of strong leadership and only token support by the Court of County Commissioners, which governs Hidalgo.

In examining the County Health Department, a number of references have been made to the Migrant Health program. If any program can be singled out as a spectacular failure, it is Migrant Health. The program is by definition aimed solely at migrants, those who have migrated within the last two years.* The program's report estimates its target population as high as 45,000. In the year beginning June, 1969, Migrant Health served 1817 migrants in family service clinics, and through its referral system made fee-for-service arrangements with doctors for 3527. Thus, under 15% of the migrant target population was reached by Migrant Health.

Migrant Health began the year with $160,790. By March 24, 1970, the outpatient service was discontinued, since the drug budget ($18,000—see budget attached as Appendix E) had been overdrawn. Hospitalization (funded at $27,767) had been discontinued on March 16, with the intention of transferring

*Effective March 12, 1970, the act was expanded to cover non-migrant seasonal workers.

those funds to out-patient services. Emphasis is to be changed from referrals to family clinics. Because the Health Department has been unable to find even one of the projected two doctors for their out-patient clinics, the program is at a virtual standstill. The balance as of July 1, 1970 was down to $37,063.11. To this, a new start supplement of $230,750.00 has been added, which will give a working balance of $268,413.11. The new funds may revitalize the Migrant Health program. We can only hope it will.

It is difficult to describe the dashed expectations of the migrant community. It was hoped, following the Yarborough hearing in Edinburg in November, that the added funds would quickly put Migrant Health back on its feet. Although the new funds cannot fail to help, the program suffers from real political and structural problems.

First, we have mentioned that the state and local matching funds do not in fact match HEW money. The matching funds represent a figure obtained by adding salaries, buildings, and other assets. This practice is doubly bad. New money is not added, and less services are available for other county needs. Texas and Hidalgo County appear not to care.

In the past, limits have had to be placed on the number of visits per patient, and even with the new funding, will undoubtedly have to be continued. As Tony Orendain once remarked, "The migrant worker here is allowed only three times a year to be sick." Due to these restrictions, families have often sent a child to the doctor's office (there are no house visits) and asked for three times the amount of medicine prescribed, on the assumption that other children, who are also sick, will need the same prescription.

The confusion that resulted from the discontinuation of Migrant Health's major programs has resulted in suspicion and distrust among the migrant community. Referrals were made, but no money was available to pay for drugs or service. The patient knew he was sick, knew what he needed, had been told he could get it, and found that in fact he would not be helped. Expectations were raised, then dashed. The program appeared doubly fraudulent, because the migrant knew the program was federal, and that the government had money. From their point of view, to say that the United States has run out of money seemed less than candid. I, who had no connection with the program whatever, felt embarrassed to try to explain to clients who came asking, "Why?"

The O.E.O. Emergency Food and Medicine program is a rather small program, which provides services only where no other health services are available. The program is budgeted, according to Mr. Eliseo Sandoval, its director, at about $200,000. About 6000 to 8000 persons come in for services each month, about 3000 of these seeking medical attention. Because of the limited funding, few of these are served.

O.E.O. officials appear to view their job as one of acculturating a resistant Mexican-American population to Anglo attitudes and values. That perspective has inevitably clashed with the new Chicano militancy. Whether a much-expanded program could be effective, under the circumstances, is therefore difficult to assess. For the moment, O.E.O. services remain circumscribed.

Hidalgo provides, through its own welfare office, about $64,000 in hospitalization payments for the indigent. The appropriation for 1970, significantly, is $50,000, $5000 less than the amount spent last year. There is also a $10,000 appropriation for hospitalization of the mentally retarded, $7,661 under the actual 1968 expenditures, $8050 under the estimated 1969 expenditures.

The Welfare Department has been the center of a small but growing storm of protests aimed, primarily, at the almost cynically negligent attitudes of its director, Mr. Tom Wingart, and his staff. Mr. David Leonard, reporting on an interview with Mr. Wingart, wrote:

"The director of Hidalgo County Welfare is Mr. Tom Wingart, who had been for many years the county sheriff, but when defeated at the polls had been appointed by County Judge Richardson to this post. A gaunt, elderly man from East Texas farm country, Mr. Wingart grew up in the depression era and remembered proudly how he had refused 'handouts' even though he made only $7.00 a week. His outlook on the valley poor was conditioned by his past. He administers the county commodity as though it was a business. He complained bitterly that it cost the county $250,000 a year to administer because of the need to truck food from warehouses in Corpus Christi. 'There's nobody starving in this county. Anyone who needs food can get it. There's really no problem here in the valley. What we don't handle, O.E.O. takes care of.' Since April, 1969, three substations had been opened in Pharr, Weslaco and Mission. The four offices are open one

day a week; all are closed Fridays 'for records, reports and Federal auditors.' Only since February, 1970 had the program been extended to cover resident aliens who could prove residence of five years, though children born in the states could receive food. (In April, as a result of the United Farm Workers Service Center lawyers filing suit, the county has eliminated the residency requirement; that is, is now in line with USDA policy.) Since January, 1969, babies can receive supplementary food, juices, farina, canned milk, when need is certified by a county Health Nurse. Mr. Wingart opposes food stamps as too expensive. 'We would have to increase the payroll.' By his attitude, experience and training, this man is fit for his position only in a county where poverty is held to be the fault of the poor and where saving public funds, or their use for "more important' things, is the higher priority."

County Welfare will pay up to $25.00 for the first day of hospitalization, and $17.50 for each day thereafter. According to Mr. Wingart, the county is going to stop payments for obstetrics.

Despite the attitudes of the staff, which from our experience in bringing the county into conformity with USDA commodity regulations, reflect the attitudes of their masters, the County Commissioners Court headed by Judge Richardson, the hospitalization program could be useful. That the program is not available to a much greater extent is due to the Commissioners Court and the local hospitals.

As Dr. Copenhaver pointed out, in quotation above, there is no longer a county hospital because "it lost money." Hospital facilities are now limited to Edinburg's hospital, the Knapp Memorial Hospital in Weslaco, a small hospital in Mission, and McAllen's General Hospital, which a visiting doctor described as quite spectacular.

It is. A large, imposing building in downtown McAllen, thanks to Hill-Burton aid, it always seems to be adding something new. The care one can receive at the hospital is impressive, and by Northern standards, reasonable in price. My daughter was delivered in the hospital this Spring, and I have only praise for the medical staff.

For the poor, McAllen hospital presents quite a different picture. Although the hospital had an excess of revenues over expenditures of almost $174,000 last year, according to their audit, they are extremely reluctant to take charity patients. They claim to do a substantial amount of charity work (see attached Hill-Burton correspondence, Appendix F), but as a local doctor has said, it keeps such care to a minimum. In our experience, the hospital has never simply admitted a patient, even from McAllen proper, as a charity case. There is thus some reason to believe that services claimed as free by the hospital may be simply uncollectable accounts.

When one looks at the hospital in more detail, the already disappointing picture begins to look frightening, almost nightmarish at times. Although a local attorney has described the hospital's operating principles as like those of a "used car lot," the hospital attempts to coerce the poor in ways which even the most unscrupulous car salesman would fear to use.

The system works basically as follows: in order to be admitted to the hospital, you must pay a deposit, which varies according to the probable treatment, but is generally in the neighborhood of $150.00. Unless you are referred by a doctor (and the deposit is demanded regardless) you will not be admitted unless you pay, or are in need of immediate, drastic treatment. A women in labor will not be admitted unless she has either paid her deposit, or her bag of waters has broken and delivery is imminent, in which case she may be lucky enough to be admitted through the emergency room.

By way of example, a Mrs. H. was pregnant. Her husband visited the hospital to arrange for the delivery. Our office, which had helped the family in a number of legal matters, was happy to see Mr. H. attempt to get hospital services for his wife. The family had long been living in execrable conditions, without even the fundamental sanitary facilities. Clearly this was a case where a sanitary trained delivery was especially desirable. But the hospital wanted too much money as deposit. When Mrs. H. entered labor, she had to seek a midwife for help. The delivery was complicated. Mother and baby survived, but Mrs. H. had to pay $100 for treatment by untrained, unsupervised and unlicensed midwife. (Texas does not license its midwives.) Thus, for lack of money, Mrs. H. was left to a system discouraged by doctors and unsanctioned by law.

Had Mrs. H. been admitted, she would have found that getting out was even harder. One of our first clients was a man who came to me and complained that the clerk at the hospital had told him that he could not take his one-day-old baby and his wife out of the hospital until he paid. I rushed to the hospital, where I was met by a profusion of denials. Of course Mr. G. could take his wife and baby, but first, how was he going to pay? I suggested to the business manager, Mr. McKellar, that the hospital might simply send the bill, and Mr. G. would pay as he could. Alternatively, a monthly billing arangement might be worked out. Mr. McKellar was uninterested. Instead, he wanted to know why I myself wouldn't pay, since I was in the charity business, or why Mr. G wouldn't sign a promissory note. Many poor people, he advised me, were "deadbeats." Perhaps because it might never have happened before that somone would come to the assistance of a poor patient, Mr. McKellar eventually relented. Mr. G. didn't sign a note, he simply took his wife and child and left. I would be surprised if he can pay the bill for a long time, because his family has scarcely enough for food.

Although Mr. McKellar is quick to deny, indeed expresses concern over, reports that personnel are telling patients that they cannot leave until their account is paid, it does happen. When I took my wife and child out of the hospital (after paying) a nurse told me just that: unless I had paid I couldn't take my family out. I replied that I hoped she was mistaken.

Some patients are induced to sign the promissory note. A Mr. P., thirty-four and married with five children, migrated last in 1966. He has a sixth grade education and an income of $3000, $2400 under the OEO poverty line for a family of his size. He receives OEO emergency food. Mr. P. brought his daughter to McAllen General Hospital for emergency treatment. The girl was admitted, although Mr. P. didn't have the $150 deposit demanded.

The final bill came to $223.60. As an indigent, Mr. P. was entitled to county welfare assistance, which would have paid $95.00 towards the account. Welfare was willing to help, but Mr. McKellar refused to accept the money. He insisted that Mr. P. pay off the balance before the hospital would accept the remaining $95 from county welfare.

Mr. P. signed a promissory note, which appears on the following page. The annual interest rate is 18%. The practice is to take such a note to a bank, particularly the First National Bank of McAllen (controlled by the Bentsen family, a member of which sits on the hospital's board). Mr. McKellar informed Mr. P.'s attorney, David Hall of our office, that in Mr. P.'s case this would not be done, as Mr. P. was too poor to be a good risk for the bank. When Mr. Hall had occasion to take his own child to the hospital to treat a case of pneumonia, Mr. McKellar asked him to sign such a note for the bank.

PROMISSORY NOTE

January 24, 1970.

(City) : McAllen.
(State) : Texas.

For value received, undersigned maker(s), jointly and severally, promise to pay to the order of McAllen General Hospital at the above place Two hundred forty-five dollars and ninety-six cents ($245.96) in 25 consecutive monthly payments of $10.00, and one of $5.96 each beginning one month from the date hereof and thereafter on the same date of each subsequent month until paid in full. Any unpaid balance may be paid, at any time, without penalty and any unearned finance charge will be refunded based on the "Rule of 78's". In the event that maker(s) default(s) on any payment, a charge of 5 percent may be assessed.

1. Proceeds	$223.60
2. (Other charges, itemized)	0
3. Amount financed (1+2)	0
4. Finance charge	$22.36
5. Total of payments	$245.96
Annual percentage rate	18

(Sign) : _____

The hospital claims that if it accepts the county welfare payment on charity cases, it runs the risk of not collecting the balance. The undiminished bill becomes a kind of lever in the hands of the hospital to put increased pressure on the patient. These payments have long been a bone of contention between the County Commissioners and the hospital which is of course a city-owned hospital, though in fact the main hospital of the county. The former are unwilling to pay more per diem. The hospital is unwilling to accept the present amount because it falls below the $52.19 average per diem expenses of the hospital. To my knowledge, no one has ever insisted that the hospital accept welfare payments in satisfaction of the *full* bill. Further, the hospital does not even seem to take into account whether, in an individual case, the welfare payments might approach the actual cost of treatment.

To continue with Mr. P., Mr. McKellar suggested he go and find a job. In fact, he said, the construction company working on the new hospital addition was having difficulty finding laborers. I checked the next day with the Texas Employment Commission, who told me this was simply not true, and that work of any kind was hard to find. To conclude Mr. P.'s story, I should point out that legally the hospital has no right to demand that a person sign a note. If the account is in default, the hospital can simply demand payment, sue if refused, and collect the legal interest rate of 6%, which is of course one-third of the interest rate on the hospital notes.

The people are well aware of the peril of becoming entangled with the hospital. One woman, a Mrs. D., had scraped up the deposit money for a serious operation. Her doctor was anxious to do the operation promptly, but Mrs. D. hesitated, fearing she would not get out of the hospital until she paid in full. She did go for the operation, but only after we advised her of her rights, and promised to assist her if the hospital tried to coerce her.

Many people are also afraid of notes, because they represent a commitment on paper. They fear reprisals through loss of their jobs, welfare, or the possibility that if they cannot pay they will never again succeed in getting treatment from doctors, or from the hospital.

The fear of signing is well-founded. Even an open account can be a distinct hazard. The hospital will give their accounts to a collection agency, which then harasses the patient with dunning notices. Some of the collection practices are overtly illegal.

Mr. P., another Mr. P., owed the hospital $105.16. The hospital gave the account to a collection agency (see a copy of a letter from Mr. McKellar to a patient advising him of the use of a collection agency. This particular note is another case.)

McALLEN GENERAL HOSPITAL,
McAllen, Tex., March 16, 1970.

Re Hospital Account for ——— in the amount of $95.60.

DEAR MR. ———: In our recent letter we advised you of our method of assigning accounts to a professional collection agency when our efforts of collection have failed.

If you will please come in to properly settle this account before the twentieth of this month, this costly collection process can be avoided.

Yours very truly,

H. A. McKELLER,
Credit Manager.

The account was handed over to the collection agency, the Central Adjustment Bureau, Inc., of San Antonio. In late April, Mr. P. received two interesting documents. One was something on green paper, legal-sized paper. It was titled, in block letters, PREPARATORY LISTING FOR CIVIL COURT.

PREPARATORY LISTING FOR CIVIL COURT

April 7, 1970
(Date)

Before the creditor files suit against you, which would show your name on the court records as a defendant in an action involving non-payment of a debt and having citation issued, we are taking this final step to strongly recommend that you mail your check to this office immediately. Should funds not be readily available, may we suggest that you contact a reputable lending institution to secure the entire amount to pay this indebtedness.

Should we not hear from you within 72 hours, it will be presumed that you do not have defenses or counterclaims to such a court action and we will be forced to recommend to our client that proceedings be started at once.

CENTRAL ADJUSTMENT BUREAU, INC.

COLLECTION DIVISION

1222 N. Main * San Antonio, Texas * CA 6-1341

May 4, 1970
(Final Date)

DETACH HERE — And Enclose With Payment in Our Self Addressed Envelope TODAY

To: CENTRAL ADJUSTMENT BUREAU — COLLECTION DIVISION

Gentlemen:

Please do not recommend suit — I am enclosing $_____ in full.

Sign Here _____

Your Address _____

Phone _____

Creditor McAllen Ross

Amount $ 105.16

DO NOT WRITE IN THIS SPACE.

☐ CANCEL ☐ FULL

☐ RECOMMEND ☐ PART

S-R

ERIC

218

216

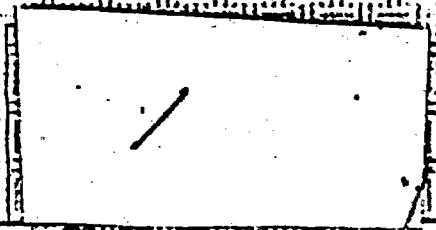
Notice of Draft Intent

A SIGHT DRAFT AGAINST YOUR BANK ACCOUNT
WILL BE ISSUED May 30, 1970

AND UNLESS

Said draft is honored upon presentation legal process will be advised to enforce payment of this account. Immediate payment will make this action unnecessary.

$ YOU OWE



Notice of Draft Intent

(Do not write in this space)

DISPOSITION OF ACCOUNT
Creditor McAllen Mun. Hosp.
Amount $ 105.16 Late Charge $
C. Costs $ Total $
Balance $
☐ Late Charge Waived ☐ Start Process
☐ Paid in Full ☐ Paid $
☐ Attitude Notice to Credit Bureau
Banking Connections

Important C.A.B.

This Notice Must Be Returned With Your Check Or Money Order Payable To "CENTRAL ADJUSTMENT BUREAU" P. O. BOX 12211 SAN ANTONIO, TEXAS.

Checks Post Dated for more than 15 days will not be accepted.

The document was unsigned, but the name of the collection agency appeared on the reply form and on the document itself. The second piece of paper was roughly the size of a check. Labelled "Notice of Draft Intent", it advised Mr. P. that "A SIGHT DRAFT AGAINST (HIS) BANK (WOULD) BE ISSUED MAY 30, 1970." Again payment was directed to be made to C.A.B., Inc. Mr. Williamson, an attorney in our office, was puzzled by the documents. There is no such thing as preparatory listing for civil court, though the document appeared to be of legal significance. Still, the document, for all its legal demeanor, was not signed by an attorney. Similarly, the sight draft was puzzling. How could the collection agency issue a "sight draft" on Mr. P.'s bank account even had he had one? Mr. Williamson was puzzled enough to refer the matter to the Texas State Bar Committee on Unauthorized Practice. A letter from the Committee, included below with the two documents, indicates that there has been a probable violation of Texas law.

A Miss S. has been receiving correspondence from the same outfit. She is not as concerned, as she is only two years old. But her father was concerned, and came to us with the papers. At the risk of duplication, they too are reproduced below. Especially interesting to us as attorneys is a card from C.A.B. which asks "Must I call your employer? If so do not call me at CA 2-8065 (signed) Robert Youngman." This case came to our office less than three weeks ago.

BECKMANN, STANARD, WOOD & KEENE,
San Antonio, Tex., May 28, 1970.

24759—State Bar of Texas (Unauthorized Practice of Law Committee).

Hon. TED BUTLER,
District Attorney, Bexar County Courthouse,
San Antonio, Tex.

DEAR TED: As Chairman of the Unauthorized Practice of Law Committee of the State Bar of Texas, I am enclosing herewith correspondence involving this Committee and a complaint received from Mr. Peter D. Williamson of McAllen, Texas.

The complaint against Central Adjustment Bureau, Inc. of 1222 North Main Avenue, San Antonio, Texas, (CA 6-1341), is obvious when you see the so-called "Preparatory Listing for Civil Court" dated April 27, 1970. It is our opinion that this character of document is not only an unauthorized practice of law, but is further in violation of Article 438c of the Penal Code of Texas.

As Mr. Davis Grant, the General Counsel for the State Bar of Texas, points out, this is usually handled by the local District Attorney's Office under Article 438c of the Penal Code and the use of this article of the Penal Code has been very effective in curtailing this practice throughout Texas.

Any assistance you can give us in this respect will be sincerely and deeply appreciated.

I send my best wishes to you, your family and your fine staff. I also take this opportunity to compliment you on the fine job you are doing as District Attorney of our County and extend my best wishes to you for your new four year term.

With every cordial best wish, believe me to be

Sincerely yours,

JOHN WOOD, Jr.

CENTRAL ADJUSTMENT BUREAU, INC.,
San Antonio, Tex., March 13, 1970.

Re McAllen Hospital; amount 160.71.

You have chosen to ignore our many requests for payment covering the above account and this is our final demand.

We would have been happy to have arranged a monthly schedule of payments, but being unable to obtain your cooperation forces us to pursue this indebtedness in a more drastic manner.

A copy of this letter has been prepared for forwarding to your employer, in the event that you fail to come to our office to make full payment within the next five days.

This method is distasteful to us, however, it has been brought about by your negligence. *Remember five days.*

Very truly yours,

J. R. HALL.

FRANZ & FRANZ,
San Antonio, Tex., April 9, 1970.

DEAR MRS.: The above account has been transferred to my office for the filing of suit. Litigation in the court of competent jurisdiction can only be avoided by your immediate attention to this matter, and I am not referring to idle conversation. This case has already been placed in my preparatory court listings, and suit will be filed against you without further notice if payment is not made within 72 hours.

It has been through your unconcern that this matter has to be handled in court. I have instructions from my client, and I am determined to collect this account at whatever expense and inconvenience.

You are doubtless aware that interest, court costs, and attorney fees will be added to the present indebtedness at the moment this suit is filed. Every known legal process will be used against you as it becomes necessary.

If you desire to avoid the additional expense and inconvenience of trial you may mail full payment to: 1019 Camden St., San Antonio, Texas 78215.

Your very truly,

CHARLES L. FRANZ, Jr.

FRANZ & FRANZ,
San Antonio, Tex., June 8, 1970.

Balance due $160.71.

DEAR MRS.: The above account has been transferred to my office for the filing of suit. Litigation in the court of competent jurisdiction can only be avoided by your immediate attention to this matter, and I am not referring to idle conversation. This case has already been placed in my preparatory court listings, and suit will be filed against you without further notice if payment is not made within 72 hours.

It has been through your unconcern that this matter has to be handled in court. I have instructions from my client, and I am determined to collect this account at whatever expense and inconvenience.

You are doubtless aware that interest, court costs, and attorney fees will be added to the present indebtedness at the moment this suit is filed. Every known legal process will be used against you as it becomes necessary.

If you desire to avoid the additional expense and inconvenience of trial you may mail full payment to: 1019 Camden St., San Antonio, Texas 78215.

Yours very truly,

CHARLES L. FRANZ, Jr.

FRANZ & FRANZ,
San Antonio, Tex., July 9, 1970.

Balance due $160.71.

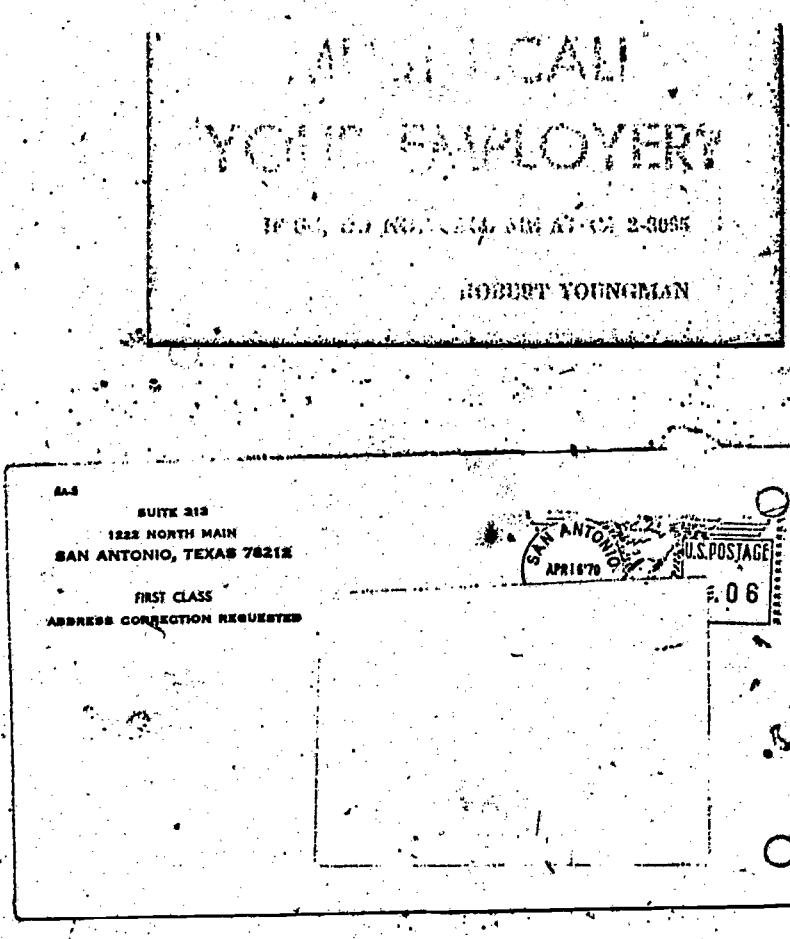
This claim has been transferred to my office with instructions to liquidate the balance within the next five days or file suit in the court of competent jurisdiction.

It is strongly recommended that you mail your check to this office immediately. If funds are not readily available may I suggest that you contact a reputable lending institution to secure the entire amount to pay this indebtedness.

If you desire to avoid the unnecessary cost and inconvenience of litigation you will comply with this request.

Yours very truly,

CHARLES L. FRANZ, Jr.


YOUR EMPLOYER
ROBERT YOUNGMAN
SUITE 213
1222 NORTH MAIN
SAN ANTONIO, TEXAS 78212
FIRST CLASS
ADDRESS CORRECTION REQUESTED
SAN ANTONIO
APR 1970
U.S. POSTAGE
06

PREPARATORY LISTING FOR CIVIL COURT

July 7, 1970
(Date)

Before the creditor files suit against you, which would show your name on the court records as a defendant in an action involving non-payment of a debt and having citation issued, we are taking this final step to strongly recommend that you mail your check to this office immediately. Should funds not be readily available, may we suggest that you contact a reputable lending institution to secure the entire amount to pay this indebtedness.

Should we not hear from you within 72 hours, it will be presumed that you do not have defenses or counterclaims to such a court action and we will be forced to recommend to our client that proceedings be started at once.

CENTRAL ADJUSTMENT BUREAU, INC.

COLLECTION DIVISION

1222 N. Main ★ San Antonio, Texas ★ CA 6-1341

July 9, 1970
(Final Date)

DETACH HERE — And Enclose With Payment in Our Self Addressed Envelope **TODAY**

To: CENTRAL ADJUSTMENT BUREAU — COLLECTION DIVISION

Gentlemen:

Please do not recommend suit — I am enclosing $ _____ in full.

Sign Here

Your Address

Phone

Creditor McAllen Mun Ho

Amount $ 160.71

DO NOT WRITE IN THIS SPACE

☐ CANCEL ☐ FUL

☐ RECOMMEND ☐ PAI

C-2 R

We have reports from two sources, a local doctor and a priest, who informed us that, at least until recently, the hospital would demand the patient's visa, if he was an alien, as collateral for payment. The priest also told us of the hospital's practice of demanding that the patient sign a blank check, even though he had no bank account. The "hot check" would then be given to the district attorney if the patient failed to pay. The priest said that late last Fall, the D.A. had some seventy-six "hot checks" forwarded by the hospital, but that he was unwilling to prosecute, to be a collection agency for the hospital. The hospital promised to stop the "hot check" racket at the time of the Yarborough hearings. The priest believes it may still be going on.

There are other examples of harassment: A Mr. R., hospitalized after an accident in the fields, was told by someone that he had to leave the hospital because his insurance company was not going to pay. A Mrs. L., who went to the hospital to make an application for welfare assistance for a child hospitalized by polio, was told she couldn't make her application there. I checked with state welfare, who said she was to make an initial application at the hospital. When I sent Mrs. L. back to the hospital, the woman at the desk told her she couldn't apply because the child wasn't eligible. I called the hospital, reminding them that it wasn't their job to decide eligibility, simply to accept the completed application. Reluctantly, the hospital accepted the application.

I have mentioned the problem with pregnant women. The hospital policy is so notorious that it is common practice for OEO and other service workers to advise women to stay away from the hospital until labor is well under way and delivery is imminent, then to go to the emergency room and hope for the best.

Finally, and to no one's surprise, the Public Health Department has been unable to persuade McAllen General to set up a referral system.

For the most part I have discussed the institutional structure of health services in Hidalgo. Dr. Love, the chairman of the Hidalgo-Starr medical society will undoubtedly answer in finer detail than I could your questions respecting the attitudes and position of the local doctors. Suffice it to point out that there are 3265 potential patients per doctor in Hidalgo, and 7206 per dentist (Starr has no dentists). (See Appendix B for CAP figures extracted from a "Forr County Rural Health Survey" prepared by Louise N. Fischer under Dr. Copenhaver's direction).

Despite the statistics, a few doctors who already have enormous practices (Dr. Casso's office may see from 80–100 patients per day) are doing an outstanding job in handling charity cases. More might help were there a system that brought concerned doctors into contact with poor patients seeking treatment. The city clinic system, which could operate to that end, doesn't because according to reports local doctors are not taking their turns at the clinic. An additional factor, omnipresent in the Valley, is that patients are reluctant to approach doctors for fear that they will only add more debts to their already crushing burdens.

There also seems to be a fundamental conflict in the philosophy of the delivery of health services among medical personnel. While the doctor's home visit has become almost unknown, public health nurses are moving in the opposite direction towards greater preventative and outreach service. If coordinated, the divergent approaches could become complimentary; at present, they are counter-effective.

I spoke of the lack of a system for bringing the needy patient and the concerned doctor together. There is also a lack of a clearinghouse to guide patients to the proper agency. The multiplicity of programs over-lap and are redundant to an astonishing degree, yet there are many who cannot find help—diabetics like Mr. R. who cannot find the treatment which he will need for the rest of his possibly abbreviated life, a mother who cannot find a Probana formula for her baby allergic to all other foods. For the poor, minor medical problems become a crisis, an emergency, a catastrophe. To be sent from agency to agency and turned down at each because you are ineligible, because funds have run out, or because you came the wrong day makes, as one observer has said, for "a world made to the mind of Franz Kafka, who alone could make it seem reasonable and normal, if not entirely just."

The system has failed to such a degree that our clinic at the National Farm Workers Service Center has been getting referrals from public agencies. At first patients would arrive with a referral slip signed, for example, by OEO. After calling O.E.O. to determine why they were referring patients to us, the referral slips began to come in blank, unsigned. Our clinic is small. It operates only three days a week, two hours a day, because we must depend on whatever time Dr.

Casso, the Service Center physician, can spare from his own practice. With one exception, no other local doctors have offered to help. The clinic is a ten by twenty foot space framed by movable partitions. Most of last winter we had no heat. During the summer it is chokingly hot. Nevertheless, for many our meager, almost ridiculously small clinic is the best and only available medical resource in the county and entirely unrelated to any government program.

THE POLITICS OF EXPLOITATION

If we look at the problem of poor health in isolation, we would be forced to conclude that disease persists for a lack of sufficiently funded intelligent programs and personnel. To do so would be a mistake, for although such conclusions may inevitably follow from the preceding analysis, we have only been talking about disease. We haven't detailed the lack of housing, food, clothing, sanitation and education upon which a healthy and productive life must be based.

We could hold hearings on any one of these areas, concluding in each that new or better governmental programs will do the trick. Unquestionably they would help in varying degrees, but the one factor underlying each deprivation, underlying, too, what is gloriously referred to as the American Way of Life, is money in a man's pocket. Until the farm workers earns a decent wage, no fundamental changes will be seen.

Food is big business. Though the small farmer is being caught, like the farmworker, by the growth of agribusiness, many people are making a lot of money by producing food. Food is such big business that even the most naive must be forced to ask himself, "If agribusiness is so profitable, why hasn't the farmworker prospered with the big growers?"

Quite obviously, he could have. He hasn't because the large growers have decided that they would rather live in imperial luxury, surrounded by want, than give their employees a fair wage. Also apparent is that far from seeking to help the farmworker in his efforts to right the imbalance, federal, state and local government has consistently abetted and encouraged the large growers.

Consider the variety of state and federal laws which exclude or discriminate against the farmworker. He was excluded from the Wagner Act. He is given a considerably lower wage under federal and Texas minimum wage laws. Despite the alarming accident rate, he is excluded from workman's compensation, forced to rely on archaic, employer-weighted tort law. He isn't entitled to unemployment compensation if laid off from field work. To qualify for coverage under any Social Security program he must earn twice as much per quarter. (Compounding the problem, some growers will not send in Social Security deductions.) As far as the Social Security Administration is concerned, a farmworker who reaches retirement age, his body gnarled from farm work, may never have earned a dollar in his life.

The catalog could go on. Rather than explore each example in detail, I should prefer to conclude with Texas' occupational health and safety laws. A memo prepared by Kitty Schild, a law student working in our office this summer, is attached as Appendix G. The thrust of the memo is that basic protections do not exist. The Texas Occupational Safety Act, which should and could be developed to provide safety standards for the transportation of migrants, for field sanitation, for drinking water, for protective devices for pesticide applicators, lies virtually dormant. There is no incentive to protect the farmworker, since it is solely upon him that the burden of accidents falls.

Then there is the border. Wetbacks and persons holding resident cards, (who really reside in Mexico), commute daily into Hidalgo during the winter, and fill the crew-leader's trucks going North in the summer. Growers encourage the permeable border, for the Mexicans will work for much less, since they cannot complain if they are paid below the minimum wage. Labor contractors know this and set up recruiting stations and shape-up stations at the bridge. When work becomes very scarce even American citizens, living in Hidalgo, will go to the shape-up station attempting to pass as a resident of Mexico. The border is doubly satisfactory to the growers, for while it contributes enormously to the already swollen labor market, it also forces the American Chicano to see his Mexican brother as the source of his problem. There is only so much work; the work must be fairly paid no matter who does it. The growers have been successful until recently in playing off brother against brother to drive wages down because there is no penalty for using illegal labor. (Tony Orendain has suggested that if growers were fined $1000 for every illegal laborer found in their fields, the use of illegals would quickly end.) That the grower-incited internecine suspicion is not

what it once was, is due to no change in the border, or in the competition, but rather the growing awareness among Mexicans and Mexican-Americans that they have a common interest in fair wages.

Well-meaning government officials have tried to help. HEW staff members came to the Valley in a series of visits designed to develop comprehensive health planning. Ray Finney prepared a memorandum of the visits, (they have come to naught), which appears as Appendix H. On the other hand, other officials clearly don't care. At a recent meeting of the Lower Rio Grande Valley Development Council twenty-five people attended. There was an active discussion for one hour on an emergency road service grant, plus a pitch from a Motorola salesman selling communication equipment. Then there was a twenty minute discussion of health care. Free clinics in McAllen and Weslaco were proposed. The Weslaco hospital administration said they didn't want the clinic, unless it could be guaranteed that there would be no cost to the hospital.

Meanwhile incredible crop subsidies pour into the Valley; $16 million annually, $8 million into Hidalgo alone (See Appendix A). One wonders who is really driving the welfare Cadillac. None of the $8 million is going to farmworkers as wages. If the growers welfare had instead been directed to the farmworker in the form of an insurance program, or direct payments, 100,000 persons could have received $80.00 a piece, and we wouldn't be here today discussing health.

The men and women who have consolidated great fortunes in the Valley have been able to do so because of a variety of factors. Some I have already touched on—the border surplus labor dynamic which has made labor a forced subsidy, strong lobbies emasculating legislation which would have treated farm labor like any other kind of labor. Heavy rural representation in Congress was equally central.

Only a sophisticated, detailed history of the growth of Hidalgo County would fully explain how the exploiters built their fortunes. For present purposes it is enough to remember that it was done in a relatively short time, mostly since the 1920's and the development of the grower-dominated irrigation districts which made possible intensive use of land. Armies of cheap Mexican labor were encouraged to come and work the fields. Cheap labor and inexpensive land fostered two other developments—the real estate speculation, in which the Bentsen family has figured prominently, and winter tourism.

I have often referred to growers as exploiters, but I have used the word loosely, and perhaps inaccurately. The exploiters are not the majority of the growers. The number of farm units in each of the four Valley counties is diminishing. The small grower is caught in a squeeze. Little profit accrues in a small growing operation, particularly in the crops grown in the Valley. Packing sheds, shippers and marketers receive the greater part of the return on the produce. Increasingly successful are the growers who also have packing and marketing facilities, like the Schuster family. Parenthetically, Frank Schuster received $77,244 in subsidies during 1969. Carl Schuster received $65,151. (Mrs. Carl Schuster remarked to an interviewer that welfare was destroying the initiative of the poor to work, and that the poor were unwilling to work when welfare is available.)

Shary Land Farm, recipient of one of the largest USDA subsidies ($125,000 in 1967, $115,000 in 1968) has its own shipping interest. Former Governor Alan Shivers married into this family. Marialice Shivers, with the same address at Shary Farm, is recorded for 1968 as receiving $26,000 in ASCS payments.

Another successful grower, packer and marketer is Griffin and Brand. Griffin and Brand, a nationwide corporation with several subsidiaries, is a salient example of a burgeoning trend to grow in Mexico, pack and ship from the United States. Attracted by cheap land and even cheaper labor, the agribusinesses like Griffin and Brand are deserting the labor force they once induced into the country. The movement to Mexico is substantial enough to worry even the Florida Fruit and Vegetable Association which, like California growing concerns, has heretofore managed to compete successfully with South Texas due to higher efficiency and superior transportation facilities.

Nevertheless, agribusinesses such as Griffin and Brand, Louisiana Strawberry and Vegetable Company, and Rio Farms continue to keep substantial land holdings in the Valley. They anticipate the demise of their smaller competitors, and continue to exploit the workers.

An interesting example of the lengths that even an operation as large as Griffin and Brand may go to to gouge their employees occurred last Fall. Workers were picking peppers for G&B at 30¢ a basket. At about 11 A.M. the field man came in and dropped the price to 25¢, retroactive. Three workers came to us to us to complain. We called the Department of Labor in McAllen, and were referred to the Harlingen office. The Department of Labor pointed out that it was Friday,

and that nothing could be done until Monday. But on Monday the investigators had a meeting upstate and would be tied up for a week or more. We called the Houston office of the Department of Labor. Two hours later Harlingen called back and announced that investigators were coming over because they had received authorization for overtime.

A packing shed ran afoul of the Department of Labor last year for the same type of minimum wage violation. The Department of Labor found that the company owed its workers approximately $10,000. On information, most of this money is still in the bank because the shed did not have to mail out the checks to the workers affected. Each worker must ask for his own check. Many did not even know that the Department of Labor had found the violation.

The kind of statement made by Mrs. Schuster, that growers cannot find labor in the Valley any more, is interesting in the context of the exodus to Mexico. A number of growers have made the same observation, and it deserves a reply. Increasingly, labor is used in very high concentrations, often in conjunction with machinery, but for very short periods of time. A typical harvesting operation on, say, a forty-acre field, may involve six or eight large trucks full of workers, perhaps over a hundred. They will harvest the field in short order, each worker earning three, maybe four dollars. Then the work is finished. The produce is hauled to the sheds, and there is no more work for the harvesters. The trucker takes a cut from the worker's pay, and he is left with almost nothing to show for his work. But despite Mrs. Schuster's complaint, I have never seen a day go by when there weren't workers available at the bridge, or in the shape-up stands in town.

The low utilization of labor and low wages also raise interesting questions about the labor cost to the grower and the consumer. A grower spends about .4 to .8 cents per pound to pick tomatoes, including a margin for waste. Repacking flats adds slightly over 1 cent, for a total labor input of 1.9 cents per pound. Sold in local markets for 29 cents a pound, labor accounts for only 7% of the retail cost. A twenty-five cent head of lettuce costs 2.2 cents to pick and pack, a one pound bag of carrots, selling for 19 cents a pound, costs only 1.2 cents to pick and pack. Higher wage scales would hardly be a disaster to anyone. Tripling wages would result in only a 2.5 cent increase in the market cost of carrots, assuming that agribusinesses tried to pass on the whole cost to the market. If all growers, packers and shippers were forced to pay the tripled wage, none would suffer a competitive disadvantage. I am not suggesting that merely tripling current wage scales would be fair, but that there is no general public interest in denying the worker a fair wage. Indeed, there is reason to believe that the poor and the middle-income consumer have interests which dictate a friendly alliance. A successful organizing effort among farmworkers would substantially reduce the need for government programs that may cost a lot, but offer little. By supporting the farmworker, the consumer is avoiding the waste of his income.

No analysis of the Valley power structure would be complete without a reference to the Bentsen family. The elder Lloyd Bentsen came to the Valley from Minnesota in the 1920's and built an extensive land business. In the intervening years the family diversified its holdings and interests. It now owns several national drug stores, banks in the county, real estate companies, mortgage and loan companies, large insurance companies, and even an agri-chemical business affiliated with Union Carbide. The family still owns extensive citrus acreage, but its primary influence is in the capital market where, with the Newhouses, it dominates the Valley. Although a Chicano-oriented bank would undoubtedly be a success, local Chicano businessmen have been frustrated in their attempts to organize such a venture by the Bentsen-Newhouse hegemony. One member of the Bentsen family sits on both the McAllen school board and the board of the hospital. (Othal Brand, of Griffin and Brand, sits with Bentsen on the school board. Both are especially reactionary.) Though less so today, the town of Mission has long been a kind of Bentsen patrimony, ruled by the Bentsens for the privileged Anglo minority. A partial list of Bentsen holdings appears as Appendix I.

The Bentsens, the Schusters, the Griffins and the Brands are but a few striking examples of Anglo domination in the Valley. 495 persons or corporations received subsidies in excess of $5000 in 1967, 466 in 1968—less than 10% of the recipients had Spanish surnames. In 1969 there were eighty payees receiving in excess of $25,000. Only one had a Spanish surname, Guerra Brothers. One expects to see even larger operations emerge. Tenneco, for example, has agricultural acreage in the Valley.

Worse than the large subsidies is the attitude of the elite towards their serfs. The most charitable point of view is that the Chicano's lot is atttributable to ignorance. Educate people, and they will know that they shou'd wash their hands before preparing food, that they should drink fresh water. Such arguments are ridiculous. Most people know they should wash their hands, but there is no clean water to wash with, because the sewage systems foul the already brackish well water. Most colonias, and many houses in cities, don't even have any water. Sewage systems are expensive to build; water beyond the reach of all but a few. One colonia pays taxes on a bond issue for a water system that runs near their boundary. They will be paying thirty-four more years. They can't drink a drop of it, can't even use it to water their gardens, because the water is only for the irrigation of large farms. Many colonias have beeen waiting for years for the F.H.A. to approve loans for water systems. One colonia, Colonia Nueva, has sought for three years to get water. An Anglo real estate dealer sold the people the land without any water rights. The well water is undrinkable, and the people have to truck in water from nearby Donna. After a long struggle to get temporary water rights, the Colonia sought to join a local water corporation, Mid-Valley, which would have applied for a loans, constructed, and administered the system. Mid-Valley refused to let them join because their allotment was only temporary, not permanent, though there was virtually no chance that the allotment wou'd have been lost. Now the colonia is going ahead on their own. If they are lucky, F.H.A. will approve their loan, and they will have water to drink. In the meantime, they are dry. We recently had a three-day rainstorm which flooded many areas. A few residents of the colonia had built cisterns. Not a drop from the deluge fell on Colonia Nueva.

The frustrations in dealing with the Anglo power structure replicate the frustrations of the sick migrant seeking a government service which would help him. At times he is met with a simile, always with a "No."

Still, the Valley has its ironies. A Catholic priest was visited early this year by representatives of one of the members of the hospital board. The board member was thinking of starting his own hospital, and wanted a few nuns around to give it aura. The hospital was to be strictly first class, calculated to take the most affluent clientele away from McAllen General. Irony, however, is infrequent.

RECOMMENDATIONS

Numerous recommendations have been offered for easing the crisis in health. One such recommendation comes from the committee formed at the suggestion of the medical society and meeting under Doctor Copenhaver's leadership. The plan, estimated to cost $1 million annually, would seek, in Dr. Love's words, to fill "a gap in delivery of health care to certain economically depressed segments of our population." (Corpus Christi Caller, June 11, 1970). Information and referral centers would be set up, along with out-patient clinics in Weslaco, Edinburg and McAllen.

I think Dr. Love would acknowledge that even with a $1 million annual budget, we will not have a comprehensive health service for all the county's poor. If, as is proposed, 12,000 persons will be treated annually, service will still fall far short of county needs. Serious cases will need hospitalization, apparently not a part of the committee's plan. More important, health will continue to deteriorate as long as water, sewage and food remain problems.

I have continually stressed what the Texas branch of the Union feels will contribute most to good health—fair wages. We do not want new programs which create complacent, tenure-oriented bureaucracies, and don't deliver. We want no new legislation, unless it is designed and is passed to support the farm worker in his struggle to gain a fair wage. We do not want legislation which purports to help, but really traps the workers in a maze of restrictions which would vitiate the farm movement.

The government and the American can help, and should. The American people pay for a dual system of welfare; the agribusinesses wax fat on subsidies, expensive public welfare systems fail to meet the needs of the poor. We appeal to our fellow citizens to consider that by supporting the Union they will be helping themselves. The Hidalgo farmworker and the consumer in New Jersey, in Minnesota, in California, Iowa, or Massachusetts, have a real stake in each other's health and well-being. The consumer boycott of grapes is a positive start. It must continue and grow until every farmworker has the rights most of us take for granted.

Donne wrote, "No man is an island, entire of itself." The plight of the farmworker diminishes us all. Let us join together and support him, like the part of us he is.

Viva la causa.

APPENDIXES

EXHIBIT A

TABLE 1.—4 COUNTIES OF THE LOWER RIO GRANDE VALLEY DATA

County	Area	1967 population	Number of farms, 1959	Number of farms, 1964	Total farm income, 1967	Total income, all sources, 1967
Hidalgo	1,541	182,192	3,575	2,868	$48,903,880	$224,242,000
Cameron	883	151,086	2,338	1,754	32,292,625	209,738,000
Starr	1,207	20,624	598	520	4,951,570	16,371,000
Willacy	595	20,084	637	547	16,490,696	23,848,000
Total	4,326	373,996	7,145	5,589	102,638,771	474,198,000

Source: Texas Almanac, 1968-69.

TABLE 2.—AGRICULTURAL STABILIZATION AND CONSERVATION PROGRAM PAYMENTS OF $5,000 OR MORE IN 1967 AND 1968

County	Number of recipients, 1967	Number of Spanish names of these	Total amounts	Number of recipients, 1968	Number of Spanish names of these	Total amounts
Hidalgo	495	24	$8,720,380	466	33	$7,654,978
Cameron	466	32	7,733,118	402	28	6,328,346
Starr	21	3	517,857	19	5	489,324
Willacy	226	7	3,198,000	207	5	2,748,373
Total	1,218	66	20,269,355	1,094	71	17,218,373

Note: In 1968 66 individuals or companys received $3,400,000 of the total payment to Hidalgo County of $7,654,978. In the 4 counties 7 farms received more than $100,000 apiece. Of the total 4-county population of 373,996, 254,766, or more than 68 percent, are Spanish-surname people.

EXHIBIT B

OEO CAP 5 FORM, SOUTH TEXAS COUNTIES

	Total	Cameron County	Hidalgo County	Starr County	Willacy County
Total population	372,123	151,098	180,904	20,037	20,084
Percent population in rural areas	28.6	25.6	28.8	60	17.9
Total number of families	75,201	31,370	36,431	3,339	4,061
Families, income less than $3,000	38,924	14,821	19,623	2,384	2,096
Percent families, income less than $3,000	51.7	47.2	53.8	71.4	51.6
Families with income less than $1,000	11,225	4,262	5,444	1,005	514
Families, income $1,000 to $1,999	15,273	5,628	7,786	949	911
Families, income $2,000 to $2,999	12,396	4,931	6,394	430	671
Males 14 and over in labor force	81,658	31,321	42,627	3,002	4,708
Percent of such males unemployed	7.1	8.7	5.8	13.8	3.5
Females 14 and over in labor force	36,363	15,914	18,290	1,348	1,811
Percent of such females unemployed	7.7	7.9	7.3	13.8	.6
Persons under 21 years of age	178,658	76,708	82,776	8,532	10,641
Percent under 21 w/AFDC payments	3.4	2.4	4.6	.06	4.0
Persons aged 65 years and over	16,586	8,093	6,477	972	1,024
Percent persons 65 and over, old age assistance	41	24	60	69	31.7
Percent persons in school (14 and 15)	87.3	88.3	86.8	90.7	80.8
Percent persons in school (16 and 17)	66.1	69.5	64.1	68.1	57.6
Number of persons 25 years and older	160,006	65,994	77,971	7,513	8,528
25 and over, less than 8th grade education	87,280	33,223	45,160	3,809	5,088
Percent 25 and over, less than 8th grade education	54.7	50.7	57.9	50.7	59.6
Persons 18 to 25 examined by selective service	2,201	288	1,527	109	277
Persons rejected by selective service	1,152	158	751	73	170
Percent persons rejected by selective service	52.3	55	49	75	61.1
Births per year	10,442	4,523	4,824	675	420
Deaths per year, infants under 12 months	(200)	179	(1)	4	4.2
All housing units	100,058	42,083	47,711	4,488	5,776
Housing units substandard	45,667	17,224	23,488	1,567	3,388
Percent of housing units substandard	45.7	40.9	49.2	35	58.7
Population with Spanish surname	254,766	96,474	128,082	15,196	13,734
Percent population with Spanish surname	68.4	64	71.3	76	68.4

[1] Not available.

Population—Towns

Hidalgo

Alamo	4,010
Cypres	20
Donna	7,650
Edcouch	2,805
Edinburg	19,500
Elsa	3,847
Faysville	50
Hargill	100
Hidlago	800
La Blanca	75
La Joya	110
La Villa	1,261
Linn	150
Los Ebanos	100
McAllen	38,600
McCook	100
Mercedes	11,143
Mission	14,281
Monte Alto	650
Monte Cristo	60
Penitas	250
Pharr	14,806
Progreso	185
Puerto Rico	350
Relampago	100
Samfordyce	95
San Carlos	150
San Juan	4,550
Sharyland	350
Stockholz	50
Sullivan City	275
Wellichville	25
Weslaco	16,550
Weslaco (North)	1,049

Starr

Ark. City	40
Delmirita	100
El Sauz	75
Escobares	250
Falcon Hts	150
Fronton	350
Garceno	175
Garciasville	250
Grulla	1,436
La Gloria	50
La Reforma	80
Los Barreras	125
Rio Grande City	6,435
Roma-Los Saanz	1,549
Rosita	215
Salineno	255
San Isidro	140
Santa Ana	80
Santa Catarina	20
Santa Blena	60
Sun Oil Camp	100
Viboras	20
La Union	20

Willacy

Lazara	150
Lyford	1,554
Porfirio	40
Port Mansfield	525
Raymondville	10,200
San Perlita	848
Sebastian	500
Willamar	40

Cameron

Bayview	268
Bluetown	100
Brownsville	52,800
Carriatos	25
Combes	510
Harlingen	41,100
La Feria	3,970
Laguna Hc	840
Laguna Vista	260
Landrum Station	125
La Paloma	150
Laureles	20
Los Fresnos	1,500
Los Indios	300
Lozano	200
Moistown	25
Olmito	200
Port Isabel	4,000
Primera	1,066
Rangerville	80
Rio Hondo	1,344
San Benito	16,650
Santa Maria	281
Santa Rosa	1,572

Counties	Cameron	Hidalgo	Starr	Willacy	Texas	National
Population [1]	160,000	200,000	20,000	22,000	10,711,743	
Persons per physician	1,684.2	3,265.6	6,666.7	4,400.0		
Physicians per 100,000 population	59.3	30.6	15	22.7	119	1,508
Persons per dentist	9,411.7	7,206.7	(2)	11,000.0		
Dentists per 100,000 population	10.6	13.9	(2)	9.1	36	54.1
Persons per R.N.	884.1	823.2	2,857.1	1,571.4		
R.N.'s per 100,000 population	113.1	119.1	35.0	63.6	173	325
Persons per P.H.N.	16,000	13,042.5	10,000	22,000	6,211	5,376
P.H.N.'s per 100,000 population	6.3	7.6	10.0	4.5	16.1	18.6
Persons per sabitarian	40,000	34,833.3	20,000	(3)		
Sanitarians per 100,000 population	.4	2.8	5.0	(3)		
Persons per registered pharmacist	2,161.6	2,518.07	1,818.1	5,500.0		
Pharmacists per 100,000 population	46.3	39.7	55.0	18.2		
Hospital beds per 1,000	2.5	2.3	2.1	1.3		3.8
Median family income (1960) [4]	$3,216	$2,790	$1,700	$2,902		$5,660

[1] Population used by 4 local health departments.
[2] No dentist.
[3] No sanitarian.
[4] U.S. census, 1960.

ERIC

EXHIBIT C

ORGANIZATION CHART
of
COUNTY HEALTH DEPARTMENT

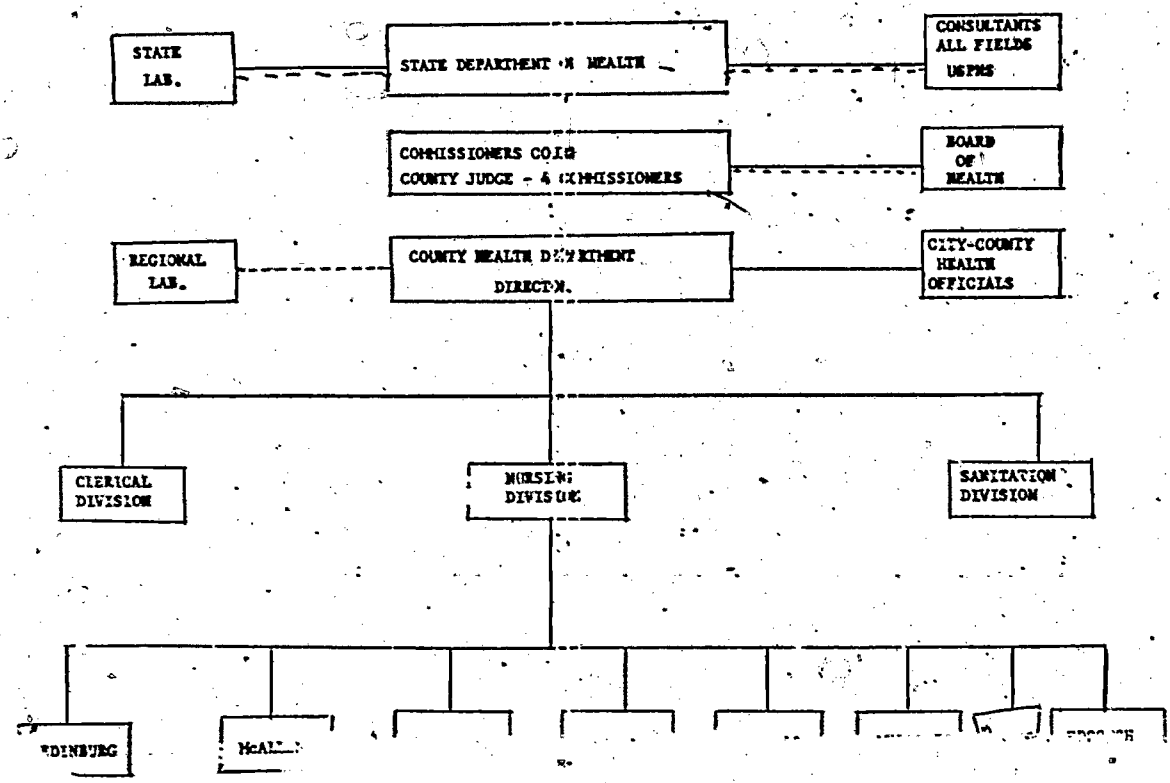


EXHIBIT D

[From Valley Morning Star, July 12, 1970]

APATHY STILL FACTOR IN BATTLE OF POLIO

WESLACO.—Anna Isabel Trevino has full brown eyes that brim with the special shine of a 2-year-old.

And she has that special smile that carries a child through happy or hard times.

Her grin never really changes. But the times have. And they are bad for the tot from Rio Bravo, Tex.

She lies in a bed at Knapp Memorial Hospital in Weslaco. She does not move her arms or legs. She has a fever, a stiff neck and sore muscles and she doesn't understand why.

Anna Isabel has polio.

The disease that was a household horror until Dr. Jonas Salk and his miracle vaccine made it rare in the late 1950s, is making a deadly comeback in the Rio Grande Valley of Texas.

STRIKES VERY YOUNG

It strikes the helpless and the innocent. It strikes the very young.

Fourteen cases of polio have been reported in Cameron and Hidalgo counties which border Mexico. Three children have died so far this summer.

"Polio is still around because of apathy," said Dr. John R. Copenhaver, health director for the two Texas counties and the man in the eye of the epidemic.

Most of the 14 polio victims were under one year of age. The oldest was 8. None of the children was immunized against the disease.

"The only way to overcome apathy is to force people to be immunized and to reward them if they do," Copenhaver said. "For instance, in order to travel or go to school or to receive welfare."

POOR HIT HARDEST

Polio can strike the rich or the poor. But in the Rio Grande Valley it has chosen the poor. Federal, state and local health officials have started an immunization campaign, dispensing 54,000 doses of oral polio vaccine in a four-county area.

The epidemic prompted state legislators and health officials to consider legal methods to force parents to have their children immunized.

"It certainly has been called to my attention," said Gus F. Mutscher, speaker of the Texas House of Representatives. "I think the best thing I could do at this time is to have a conference with the head of the Texas Education Agency and the Health Department."

Many cities and school boards have required polio immunization. But Dr. J. E. Peavy, state health commissioner, said school programs would not help the current outbreak.

"All but one of the children involved are under 2 years of age," Peavy said.

URGES EARLIER START

Copenhaver said school programs do not attack the disease early enough in children.

"We can't afford to wait until they are school age," he said. "They should be immunized in the first year of birth. It could be made mandatory for a birth certificate."

Anna Isabel Trevino got her birth certificate and was struck down by polio in her second summer because she was not immunized.

The Texas State Health Department now sends to county health departments lists of infants born in their areas. County officials then mail letters to all mothers, urging them to have their children inoculated.

ADDRESS PROBLEM

"But the address is so frequently wrong. It makes it awfully difficult," Copenhaver said. "We are now recommending that more information be given so children can be accurately followed up.

"When they come into the clinic, they receive all the immunizations—diptheria, whooping cough, tetanus, measles and smallpox—as many as two at one time."

The treatment is free for those who cannot afford it.

Despite the free clinics, door-to-door campaigns this summer and warning letters, polio continues to pop up, especially among the poor.

"I don't think the financial status has anything to do with polio" except for the lack of money to pay for regular visits to a pediatrician, Copenhaver said. "The sanitary conditions or the closeness of individuals might be involved."

CROWDED LIVING CONDITIONS

Many Mexican-Americans in the Rio Grande Valley, including thousands of migrant farm workers, live crowded together with substandard sanitary conditions.

The upper respiratory virus that causes polio can be inhaled through cough droplets from another person or transmitted directly by body filth found in all economic levels, Copenhaver said.

He said surveys indicate the large migrant families are immunized better than nonmigrant families "because we put more emphasis on our migrant program here and there is emphasis up and down the migrant streams."

EXHIBIT E

HIDALGO FEDERAL MIGRANT HEALTH 1970 BUDGET, UNOFFICIAL[1]

Categories	Approved	January	February	Balance Feb. 28, 1970
Salaries	$53,716	$3,782.00	$4,435.00	$45,499.00
Physician fees	19,000	4,899.00	4,995.00	9,106.00
Office supplies	500	0	26.59	473.41
Drugs	18,000	5,616.61	13,916.49	[2] —1,533.10
Clinic supplies	120	0	0	120.00
Travel	7,896	479.83	358.27	7,057.90
Equipment	0	0	0	0
Printing	400	0	112.65	287.35
X-rays	3,000	535.00	463.50	2,001.50
Lab	3,000	563.00	750.50	1,686.50
Hospitalization	27,767	0	0	27,767.00
Physician care	26,000	300.00	40.00	25,660.00
Ambulance	1,000	0	0	1,000.00
Postage and communication	400	0	0	400.00
Total	160,799	16,175.44	25,096.00	119,525.00

[1] County medical program given to NFWSC by Dr. Copenhaver, director. January 1 to December 31.
[2] Over.

EXHIBIT F

UNITED FARM WORKERS ORGANIZING COMMITTEE AFL–CIO,
McAllen, Tex., April 11, 1970.

Dr. J. E. PEAVY,
Commissioner of Health, Austin, Tex.

DEAR SIR: The "Monitor," a local newspaper, reported on Tuesday, April 7 that the McAllen General Hospital is applying for additional Hill-Burton funds for the construction of more patient's rooms.

We support, without reservation, the need for additional funds. We would ask, however, that in processing the McAllen application, state and federal officials scrutinize with great care McAllen's assurances that it will provide a reasonable volume of services to persons unable to pay for them, assurances required by the Act and supporting regulations.

A recent medical survey conducted in this area of the Rio Grande Valley showed an alarming lack of medical services for the poor. There is no question but that our hospitals, McAllen General included, must be vastly expanded to handle the critical medical problems we know exist. Unhappily, we are not convinced that McAllen General takes seriously its obligation to serve the poor, as it serves the rich. The hospital has received Hill-Burton funds in the past and will, we hope, receive more at this time; but testimony at a senate Subcommittee hearing in Edinburg last Fall and our own experience show that the hospital is turning away many of those who cannot afford entrance deposits and harassing the indigent for payments.

Under the circumstances, we would ask that the mandatory assurances be spelled out in great detail and made easily available to the public. Among other questions we would ask are: What percentage of indigents applying for admission and treatment have been admitted as charity patients? How many have been turned away? What percentage of the proposed rooms will be available to those unable to pay? Will the hospital treat such patients as true charity patients, or will it continue its apparent policy of harrassing the medically indigent? Will other services of the hospital be made available to indigents on an expanded basis?

I wish to make it perfectly clear once again that we do not oppose an additional grant of Hill-Burton funds; we support such a grant. Our concern is that the spirit and the letter of the Act, that the poor have a right to share in federally assisted medical programs, be met. The hospital, by its own admission, is in good financial shape. McAllen General can and should comply with the responsibilities that go with Hill-Burton funds.

Thousands of the Valley's poor are suffering from critical medical problems, some of which have gone beyond the point of cure only because they were too poor to get the treatment they know they need. Hill-Burton dollars will make no difference to the destitute, waiting in their agony, until and unless Texas and the United States government stand behind and guarantee the promises Congress made to the poor when they passed Hill-Burton.

Very truly yours,

ANTONIO ORENDAIN.

TEXAS STATE DEPARTMENT OF HEALTH,
Austin, Tex., April 16, 1970.

MR. ANTONIO ORENDAIN,
United Farm Workers Organizing Committee AFL–CIO,
McAllen, Tex.

DEAR MR. ORENDAIN: I appreciate very much your letter to me, dated April 11, 1970, expressing your interest in and approval of a Hill-Burton grant to the McAllen General Hospital. We regret very much that we did not have sufficient funds to make an allocation to this project. We realize that this facility is badly needed in the area and perhaps, if the hospital reapplies next year, we might receive a larger sum under the Hill-Burton program and be in a position to make allocations to a larger number of hospitals than we were able to this year.

Very truly yours,

J. E. PEAVY, M.D.,
Commissioner of Health.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
PUBLIC HEALTH SERVICE,
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION,
Rockville, Md., June 2, 1970.

MR. ANTONIO ORENDAIN,
United Farm Workers Organizing Committee AFL–CIO, Texas Branch,
McAllen, Tex.

DEAR MR. ORENDAIN: This is in further reply to your letter of April 11, 1970, to Dr. Harold Graning, with reference to the McAllen General Hospital's request for Hill-Burton funds and your questions pertaining to assurances for service to persons unable to pay.

We have received a report on the matter, through our Dallas Regional Office, from the State Department of Health, the administering authority for the Hill-Burton program in Texas. We are advised that due to the limited funds allotted to the State of Texas, the State agency was not able to make an allocation to the McAllen General Hospital, and therefore the assurance pertaining to patients unable to pay for services does not apply in this instance.

With reference to your questions concerning the admission of indigent patients, we have been advised that the McAllen General Hospital from October 1, 1969, through April 30, 1970, furnished 348 patients (9 percent of the admitted patients) with services amounting to $73,914 (5 percent of the gross patient revenue), and the hospital's estimate is that it will furnish over $100,000 in free service to local citizens before the current hospital fiscal year is ended.

Sincerely yours,

TED L. BECHTEL,
Director, Office of State Plans.

JUNE 24, 1970.

Mr. TED L. BECHTEL
Director, Office of State Plans,
Department of Health, Education, and Welfare,
Public Health Service,
Health Services and Mental Health Administration,
Rockville, Md.

DEAR SIR: Thank you for your interesting letter. It is reassuring to hear that McAllen Hospital may be offering charitable services to local citizens. At the risk of sounding skeptical, I should like to ask if you know, or can find out, whether the "free service" is indeed free, or represents indigent patients who have been harassed for payments, but who have no money.

Our experience with the hospital has revealed a number of instances of patient harassment, and no instances of true charity. I would be ready to applaud the hospital for charity work, if I were sure that it is providing it. You will understand my hesitancy in accepting the hospital's figures until such time as we can be sure they represent real charity.

Very truly yours,

ANTONIO ORENDAIN.

EXHIBIT G

TEXAS PROVISIONS FOR HEALTH OF FARM WORKERS AND PACKERS

(By Kitty Schild)

Texas safety and health statutes, or the lack of them, contribute directly to poor farmworker health. Huge gaps exist in legislation, the few laws existing are unenforced. The basic statute involved is the Occupational Safety Act, V.A.C.S. Art. 5182 a. It applies to all employers (defined as anyone in control of any employment, place of employment, or employees, with the exception of domestic help or those employed on carriers regulated by the ICC.) It merely requires that such employers must maintain a *reasonably* safe and healthy place to work. They must use any processes or devices, including methods of sanitation and hygiene, as are *reasonably* necessary to protect the life, health, and safety of their employees.

However, any more specific rules or regulations must come from the Occupation Safety Board, composed of the Commissioners of Labor Statistics and Health and a public member appointed by the governor. The Board may also exempt any individual or group from any of its rules or regulations. The Board has not yet promulgated rules covering agricultural workers, and probably will not for several years, if ever.

Besides this very general statute, there are a series of statutes that apply to any factory, mill, workshop, mercantile establishment, laundry, or other establishment which employs females. These would apply to packing sheds and probably agricultural work, though this latter is not listed and would have to be considered as "other establishments." (On an earlier statute, Art. 5172a, concerning hours for female employees, those involved in the "first processing" or in canning or packing fruits or vegetables were specifically exempted, so one could argue that since they weren't so exempted in these articles, they were meant to be included.)

These statutes provide that such establishments should take adequate measures for maintaining a reasonable. and if possible, equable, temperature, *consistent with the reasonable requirement of the manufacturing process.* There shall also be no gas or effluvia from sewers, drains, privies, etc., and poisonous or noxious gases and dust must be removed as far as *practicable.* V.A.C.S. Art. 5174. Floors shall be cleaned at least once a day and if the manufacturing process wets the floor, there should be adequate drainage and grates or dry standing room where practicable. V.A.C.S. Art. 5175. Exits should open outwards and be easy and quick to open. Handrails and adequate lighting must be provided for any stairs. V.A.C.S. Art. 5176. As can be seen by reading the above statutes, a specific rule will be set and then watered down with such phrases as "as far as practicable" or "consistent with the reasonable requirements of the manufacturing process."

The only statute without such provisions (and one which also applies to male employees) is Art. 5177 which requires toilets in proportion of one to twenty female employees, and one to twenty-five male employees. There must be separate

toilets for males and females, and they must be constructed in an approved manner and properly enclosed. They must be kept clean and sanitary, disinfected and ventilated at all times and lighted during working hours.

All the above statutes (Arts. 5173–5178) are to be enforced by the Commissioner of Labor Statistics.

Strikingly absent are provisions protecting laborers in transit to and from the fields. As many as twenty migrants—men, women, and children—may be loaded into the open, unprotected cargo space of a flatbed truck. There are no seats, overhead protection, or safety belts. With this lack of protection, an otherwise minor accident can turn into a major tragedy.

Also lacking, as yet, are provisions for water and toilets in the *field*. Failing basic sanitation and comfort standards, the workers cannot be blamed for excreting in the fields. Some of the more modest, particularly women, have suffered kidney and bladder disorders from long hours of working without urinating.

EXHIBIT H

Visits by Federal Officials to the Lower Rio Grande Valley the Past 18 Months

It should be noted that there have been a steady stream of federal and state officials coming through the Valley this past 18 months. They have held meetings, promising things, then vanishing, and nothing happened. Basically there is no follow-up.

The following is a list of visits by Federal officials to the Farm worker groups in the Valley over the past 18 months.

VISITS

Anril 1969.—Dr. Bud Shenkin, USPHS. Wash. D.C. and Dr. Tom Newman USPHS Dallas Regional office. They discussed with Colonias del Valle the possibility of a health grant. Either a clinic or a community health aide program that could refer people to existing facilities.

August 1969.—Colonias people wanted a clinic to deliver services and therefore during July and August a survey was done to develop a clinic serving 12 rural colonias and a research project to develop a comprehensive plan for the whole Valley. (4 counties). Aides would do no good because there were no services available to refer to.

September 1969.—A 12 colonia survey was done and a proposal submitted to USPHS for a clinic and planning grant. This proposal was supported by the Farm Workers Service Center.

October 1969.—The submitted proposal was reviewed by the USPHS, consumer review committee, and action was postponed until Jan. 1970.

November 1969.—Discuussion of health problems with Miss Helen Johnson of USPHS Migrant Health branch. No real results could be seen due to no funds available to Migrant Health branch.

Hearings on Migrant Health by Senator Yarborough's Committee in Edinburg. Much effort was made to develop good and true testimony. There was much distrust of the value of these hearings especially on the part of the young migrant people, because these hearings had been held before and no real advantage or gain to the poor.

In Feb. of 1970 more money was allocated but this did no real good because the majority of the funds did not go to Texas. Also most of the money went to support clinics. To most of us, migrant clinics are like Bingo if you live near one, you win until the money runs out. If you don't live near one you loose. The money never goes directly to the farm workers either via stamps or insurance, so he has to accept what over he can get after the health Bureaucrats, Administrators, and Health providers have taken their cent.

December 10, 1969.—Farm Workers Clinic opens.

December 1969.—Glenn Bell, and Bob Winston of the Dallas Regional Office plus Bud Shenkin of USPHS in D.C. came by to discuss the October proposal, plus the newly opened Farm Workers Clinic staffed voluntarily by 1 local doctor and several nurses.

It should be noted that on each of these trips the Federal people promised support and assistance in whatever we wanted. They told us, they were for us and would help in every way. It was only much later that we found out, they were saying these same things to the doctors, pharmacists, and county health workers and other community groups.

February 1970.—Another meeting was held with representatives from USPHS. This time in D.C. with people from the D.C. office. Again promises of assistance and interest.

March 1970.—Mr. Glen Bell and Dr. Tom Newman of USPHS Dallas came to the Valley to ask for proposals for the new Migrant Money (Yarborough's money). They were selling clinics as "the thing D.C. USPHS wanted to fund". The farm workers asked for Health Stamps (a food stamp, insurance type program). We did not find out until later (June 5), but the pharmacists asked Bell and Co. for a Medical insurance program and the doctors were split some wanting fee for service insurance and some wanting a government run welfare clinic attached to hospitals. The last of these choices gained favor with the government people and was funded in June. It is interesting to note that the majority of those involved (Farm workers, pharmacists, and doctors) wanted almost the same thing.

Following Bell and Newman's visit a proposal for 3.2 million to cover farm workers specifically in the four counties and generally in the mid western states was submitted to USPHS. Except for one phone call from Dallas, this proposal was completely ignored. In June we learned that the Medical Society Clinic was to be funded. The amount of $230,750 was allocated to Hidalgo Co. (our cut of the $7,000,000 Yarborough appropriation for Migrant Health, the benefits of the Nov. hearings). The interesting thing, is that this money is to be spent and supervised by a small committee made up of Medical Society and government people. The ideas and proposal which the farm worker groups submitted was never taken even as far as the national review committee. Another tragedy is that the money presently is not being spent because the doctors and government people can't find a $30,000 doctor to staff their own brain child. The farm worker groups had asked first for a Health Stamp or insurance type plan that spread the poverty medicine practice around. One reason being this would avoid the direct recruitment of one doctor for a government type charity clinic and possibly attract more private practitioners.

The best lesson that can be learned by all of this, the Yarborough hearings included, is that the people should never expect much from the government. There are too many obstacles between the Halls of Congress and the rural areas, such as the Valley. The fight for individual rights, for better pay and better public services has to be carried on at the local level. All we can hope is that the majority of the American people and the Congress will help us by being aware of the plight of the rural poor and stop helping the agri-business men and the entrenched government agency people.

As long as the agri-business men receive a double subsidy first via direct crop support or said bank payments and second via subsidized labor (Health projects, food commodity distribution, private charity to impoverished workers) it will be impossible to make economic and social progress in rural areas. The poor have no choice but to migrate to the urban centers. In most cases this migration only adds to frustration, despair and unrest.

* * * * * * *

PREPARED STATEMENT OF JOSEPH C. SEGOR, EXECUTIVE DIRECTOR, MIGRANT SERVICES FOUNDATION, INC.

Mr. Chairman, members of the subcommittee, my name is Joseph C. Segor. I am the Executive Director of the Migrant Services Foundation, Inc. I am a lawyer and for the past several years have concentrated my efforts on the problems of farmworkers. From May 1967 to September 1969, I was the Executive Director of Florida Rural Legal Services, Inc., an OEO funded legal services program operating in seven south Florida counties.

The Migrant Services Foundation is privately financed and provides legal and other services to farmworkers in Florida. We are headquartered in Miami, but operate throughout the State. My companion is Rodolfo Juarez, Executive Director of Organized Migrants in Community Action, Inc. (OMICA), the largest farmworker organization in Florida. He was born and raised a migrant, eventually becoming a crew leader. Recognizing the exploitation of migrants by crew leaders as well as others, he quit, at great financial sacrifice, to work for several OEO rural programs prior to becoming the operating head of OMICA. OMICA maintains a full-time office in Homestead, Dade County, Florida and has chapters in a number of locations throughout the State.

I will present a short prepared statement after which we will both be happy to answer questions.

Mr. Chairman, the newspapers and news programs have been filled with accusations by growers, agribusiness organizations, and political leaders in our state that the recently aired NBC Migrant White Paper produced by Martin Carr and narrated by Chet Huntley was biased. These individuals and organizations were so certain of their position that they made their accusations even before they saw the show. Our Governor, whose protests were among the loudest, appeared to be trying to create a self fulling prophecy of bias by declining to appear on the program.

The dictionary teaches that bias implies unreasoned and unfair distortion of judgment in favor of or against a person or thing. It is the thesis of my remarks that the State of Florida, through its governmental institutions at all levels, as well as its social and economic structures is biased against the farmworkers. I would modify the dictionary definition somewhat, however, because in my opinion the bias which oppresses farmworkers is in many instances not unreasoned, but a deliberate, calculated and purposeful attempt to maintain an economic advantage regardless of the cost in human misery. Also, inextricably connected to the economic motivation is a deep and pervasive racism that permiates all of rural and much of urban Florida. Present too is a hypocritical selfishness that masks itself in a philosophy of radical individualism and surfaces as an extreme hostility to programs, especially federal programs, intended to aid the needy, the helpless and the powerless, particularly when these are Black, Chicano, or Puerto Rican. At the same time, every effort is made to obtain federal largess which benefits the dominant economic, political and social groups.

The abuse heaped upon NBC was only one minor manifestation of the foregoing characteristics. To anyone familiar with migrants, the NBC show understated rather than overstated their problems. I have seen places such as Jerome that are worse than any shown on the show. The feeling of oppressiveness that occurs cannot be shown on TV. It can only be lived. The conclusion of that show that all Americans are responsible is wrong; particular men and institutions are at fault, they should not be allowed to hide in the crowd.

A specially good example of institutional hostility to farmworkers was the State response to their pleas in the spring of this year that they be accorded the unemployment benefits provided in the Disaster Relief Act of 1969.

A complete account of this shameful episode is contained in my report to the Board of Directors of the Migrant Services Foundation, Inc., a copy of which is attached as an appendix to these remarks. Perhaps the best short summary of what happened is contained in a headline from the Fort Myers (Fla.) News-Press of April 10, 1970, which read, "Disaster Relief: Farmers Get It, Migrants Want It." Unfortunately, or more properly I should say tragically, they did not get. The motives that lead growers and State officials to combine to prevent the migrants from receiving assistance specifically provided by the Congress for

their benefit must inevitably remain conjectural, but the consistently repeated viewpoint that migrants won't work if they learn that they can get something for nothing is, no doubt, at least part of the answer. It is never explained why, if migrants are paid as well as growers claim, they would want to continue on a dole providing a maximum of forty dollars per week. Nor why, in other contexts, they would prefer to get commodities, food stamps or welfare, assistance, rather than work for the bountiful wages claimed to exist. (See Miami News article of July 17, 1970.) This managerial philosophy of "starv'em or else they won't work" appears to be a rationalization that allows the growers and their allies to live with the exploitive system they control. This rationalizing process takes another and perhaps more pernicious form in the "let's appear to do something for them" syndrome. This takes two primary forms. The first involves the making of promises without any attempt at delivery. A good example of this was Governor Kirk's "Action Plan" unfolded in the spring of 1969. Some of the target dates contained in the plan are interesting and in a morbid way amusing. April 15, 1969—"GO." April 16, 1969—State Advisory Commission on Migratory Farm Service appointed. April 21, 1969—Joint meeting in Tallahassee of federal, state and local officials to create task forces. May 1, 1969–June 15, 1969—all existing migrant programs in state evaluated by onsite inspection of specialists. . . ." July 16, 1969, report and recommendations to Governor and federal agencies. August 15, 1969, coordinated program underway. The migrants are still waiting for this one. No doubt they'll continue to wait.

The other manifestation of the "let's appear to do something for them" is actual creation of an institution that will appear to do something, but either because of its basic design or its manner or operation or both, will in fact do nothing.

A fine example of this purposefully bad kind of engineering is the recently enacted statute creating "the Florida Legislative Commission on Migrant Labor and an Advisory Committee Thereto." The bill makes a pass at recognizing that there is a problem by stating that ". . . the most economically and socially deprived segment of population in the United States of America consist of those persons generally referred to as migrant farmworkers. . . ." It goes on to create a commission composed of three members from each house of the legislature. The commission is authorized to enter into "agreements for the establishment of cooperative arrangements" with other states. The Governor is authorized to enter into an "interstate migrant labor compact" in substantially the form set forth in the statute. The compact would set up an interstate migrant commission which would only have the power to do research, suggest proposals and cooperate with other agencies. In essence, the commission would be powerless and would be dependent for financing upon state appropriations to be requested by it. This toothless tiger is only one illusion contained in the bill.

The other is an advisory committee composed of representatives of five state agencies, four enumerated grower organizations and, presumably for balance, a representative of the Florida state federated labor council. This latter choice is unique in that if there is one place the farmworkers are not represented it is the Labor Council. There are also positions open for not less than two, nor more than four other persons selected and appointed by the commission. There is not the slightest guarantee that the farmworkers will be directly or even indirectly represented by anyone close to them. The legislative commission was created without any consultation with farmworker organizations or their allies, although these are well known to the legislature. Three of the grower organizations were added at the demand of a grower lobbyist. It can be expected that the additional representatives will be "safe" people not likely to cause controversy by strong and persistent advocacy of farmworkers rights.

Even if good people are added to the committee, the whole focus of the bill is outward toward an amorphous alliance of states to occur at some unknown and inevitably far distant date when a dozen or more state legislatures can get around to ratifying the pact. It completely avoids the need to turn and look at the problems within Florida and to devise solutions for them. In sum, the bill is a cruel and preposterous hoax.

Having dealt with the institutional biases of our state executive and legislative branches, I would like now to turn to the operation of existing programs at the local level. Naturally, among these there are substantial variations in how they perform, depending in part upon the agency concerned and geographic location. Nonetheless, a few generalizations can be made. From reports given to me as well as personal experiences, I can say that state and local agencies are:

(1) Not run for the convenience of those they serve, the farmworkers, but for the convenience of the staffs.

(2) The local offices are dominated by grower interests and use the benefits they confer to require the farmworkers to conform to those interests.

(3) There is little, if any, outreach, so that often those most in need of help do not get it. This can happen either because the farmworkers have not been informed of the services offered or the services are dispsensed at times or places which the farmworkers cannot reach.

(4) The agency staffs often have negative attitudes toward their clients, in many cases these attitudes are basically racist. The attitudes all too often manifest themselves in indifference, impoliteness, harshness and sometimes cruelty.

(5) Agency personnel instead of earnestly trying to help prove eligibility, do everything possible to prevent the clients from establishing their rights to aid.

Innumerable cases can be recounted in support of the foregoing. A few will suffice. In many counties, welfare and food distribution offices are located in places that the poor cannot reach by any means other than private automobile. I have been told that in Polk County the commodity distribution office is located at an out of the way spot, and the cost of reaching the place amounts to as much as one-tenth of some welfare clients checks.

When a representative of the Florida Christian Migrant Ministry approached the director of distribution in this county about opening several distribution points, he was told that the county commission had already turned down the suggestion as too expensive. One county commissioner was quoted in the press as saying "the next thing the poor will want is for us to go to their homes and cook the food for them."

When the Director was queried about making the hours more convenient to farmworkers, the office was open from 8:30 to 3:30, Monday thru Friday, he asked why he and his staff should be inconvenienced for the farmworkers convenience? To the reply that the reason was that they serve the poor, he said that he had a responsibility to his employees.

This same man added that if the poor really want the food they would get to the distribution center when it was open. Many people applying for food at this center have been turned down three and four times because the county employees make no attempt to help them comply with the regulations. One requirement is that the farmworker show his last pay check or a letter from an employer stating his earnings. This is often impossible for people who are paid cash and often work for many employers. Variations of this theme are heard from sources throughout the state. Attempts to get mobile food distribution units for rural areas have generally been rebuffed.

In the same county, I spoke of before, the welfare office is located at an old airport which is hard to reach. AFDC mothers who must go to see their social workers must either pay to get there or rely on others. As a result, they often come late or miss their appointments altogether.

In Polk County there hasn't been a migrant health project for two years. The local health department was unwilling to keep separate records for migrants and therefore was unable to comply with federal regulations. As a result it pulled out of the program. The health department's convenience, in this case, was clearly more important to the county health officer than the health of farmworkers. No doubt, he would feel very much put upon if he were told his job depended on getting the project back.

Collier County's Food Stamp Program has proof of income rules similar to those previously enumerated. Many farmworkers can't comply with them. In addition, the food stamp personnel will check eligibility by asking employers what they expect the applicant to earn the following month. Because of the pervasive hostility of growers to the program, they will often make high projections, thus leaving the individual and his family ineligible. When a local Black and a Chicano leader went to the county commission to protest this practice, they were told they could not do so because they had participated in a peaceful demonstration.

The Director of the American Friends Service Committee Migrant Project which operates a housing program has informed me that he has had to abandon trying to qualify farmworkers for section 235 housing loans because of the use of such middle class eligibility requirements as holding a job for two years and providing W-2 forms. Farmworker employment practices, of course, making this

impossible. The AFSC has now switched to the Farmers Home Administration, but this limits the number of houses that can be built.

Ironically, my experience in the housing field is just the opposite of that of AFSC. In 1968, when I was Executive Director of Florida Rural Legal Services, our Belle Glade office began work on a housing project for Pahokee, a nearby town. After many months of planning, an application for a large project was filed. It was turned down by Farmers Home Administration with the assertion that the authorizing legislation did not allow them to make this size loan. It was our opinion, as well as that of the counsel of a consulting firm we were using, that this interpretation was wrong. We were joined in our opinion by Congressman Paul Rogers, who protested, but to no avail. We finally had to abandon Farmers Home and begin again with FHA. I am informed that after two and a half years of effort the first models will shortly be constructed.

That racism prevails cannot be denied. In Lee County it has been necessary to file suit to integrate the County nursing homes. In that same County, a Doctor quit the welfare program after a suit was brought to require him, among other things, to integrate his waiting room.

Innumerable instances have been recounted of hospitals which have received Hill-Burton funds refusing to treat indigents. In Homestead, I have attended meetings where the feeling of hatred expressed by Blacks and Chicanos against the local James Archer Smith hospital was so intense it was almost unbearable. Their complaints involved both failure to care for the poor and racism. They feel so strongly that they do not want a federally funded migrant health project that will shortly open up to even attempt to get services from the hospital. This, despite the fact that the next closest hospital is 15 miles away by way of a heavily trafficked road.

Other witnesses have discussed the absence of basic legal protections for farmworkers and the reports of this committee have collected valuable data on this point. I will just point out that it is not only lack of laws that create difficulties, but also the impotence of endorcement agencies. For instance, the health department which is charged with inspecting migrant camps in Florida does not have lawyers to file suit against violators. It must rely upon county prosecutors who look upon this type of activity as a nuisance taking away from their crime duties. In those places where the prosecutor has a private practice, there may actually be conflicts of interests.

Even if the Health Department had enforcement powers, its regulations are a fraud, being hardly worth the effort to enforce. The same is true of the federal regulations on migrant housing.

I am informed that in Palm Beach County the Health Department shys away from environmental health problems as opposed to clinical ones because of the fear of possible political repercussions. This fear of political retaliation is ever present and effects the activities and operations of even the most dedicated program and workers.

It is in this context that I come to my next point which is that there is an interchange between intransient institutions and biased people, back again between biased people and intransigent institutions that paralyzes efforts to obtain needed change. We are constantly told the farmworkers are content with their lives, won't work and won't help themselves. Yet, when there is a chance, that farmworkers will engaged in the processes that lead to change, intense efforts are made to frustrate them.

I have seen a report, which I believe to be valid, which told of one large farmer providing buses for his workers to attend a picnic on election day. This was to prevent the workers from exercising their franchise. A black leader in Immokalee told me that the same type of thing occurred on the day a referendum was held on the question of incorporating the town. Naturally, the White farmers and businessmen who owned property did not want to be part of a city in which the majority of the voting population was Black and Chicano.

The power of agribusiness to thwart the democratic processes in order to prevent farmworkers from obtaining benefits that other working people take for granted is notorious. In 1969, agribusiness was taken by surprise and a bill eliminating the farmworker workmen's compensation exemption was voted out of committee in both houses of our state legislature. Despite a last minute lobbying effort, the bill passed the Senate by two votes.

Unfortunately, it did not get on the special order calendar in the House and time ran out. This year the lobbyists were ready and the Friends of Farmworkers in the legislature could not even get a watered-down version of the bill out of committee.

The tragic effects of grower opposition to this most elementary form of social legislation is set forth in an article that appeared in the July 16, 1970, issue of the Palm Beach Post. The article quotes a vocational counselor for the Florida Council for the Blind, as saying that he sees as many cases of blindness among glades agricultural workers as there are in the rest of Palm Beach County, although the agricultural population makes up less than 10% of the county population. He attributes the high incidence of eye disease to the swirling muck dust encountered by the workers. First, it would provide more immediate medical care to the workers who are injured by the dust. Second, many of our industrial safety practices have resulted from the pressure of insurance companies on business to get it to upgrade standards. We could probably expect the same to happen in agriculture were workmens compensation to be universally extended to the workers.

Returning to the local scene, a classic example of community sabotage of a needed federal project recently occurred in Immokalee. A doctor from the University of Miami's School of Medicine became interested in setting up a major clinic there under the Migrant Health Act. With the support of the U.S. Public Health Service he began to discuss the proposed project with all segments of the community, not only in Immokalee, but also in the county seat at Naples. He touched all the bases, and lined up support from growers, business people, the Health Department, the County Commissioner for the area and, so he thought, the county Medical Society. All this in addition to the enthusiastic support of the intended consumers. However, when a public meeting was held to discuss the project, he was shot down by the local doctors by the use of a clever ploy. The doctors told the people that what they needed was not a clinic but a hospital. Naturally, everyone became excited over the idea and the Migrant Health Act clinic was forgotten.

A board was formed under the chairmanship of the one private physician in Immokalee to begin raising money. This physician, along with the local druggist had been prime opponents of the clinic. The physician had even gone so far as to threaten to quit practice if the clinic came in. The upshot of this is that little or nothing has been done to further the hospital in the year that has elapsed and the clinic will be located in the more hospitable climate of Dade County.

From public reports and talks with various people familiar with what occurred, I have been able to come to the following conclusions.

(1) Attitudes toward the project were deeply affected by prevailing hostility toward federal projects. Although interestingly enough, this did not extend to shyness about applying for Hill-Burton funds. This generalized anti-federal hostility made otherwise hard-headed people receptive to a pie in the sky hospital plan despite the fact that the community's small size militated against such a hospital being successful. It also blinded people to the possibility that the clinic could be used as a base upon which to build plans for a future hospital as has been proposed for the south end of Dade County.

(2) The local physician and druggist were afraid of competition from the clinic and put their own economic well-being ahead of that of the people.

(3) The County Medical Society was afraid that the clinic would raise the farmworkers level of expectations concerning medical care to too high a level.

(4) The dominant community feared extensive consumer participation on the governing board of the clinic. Both because such participation, if successful, will do violence to prevailing racial attitudes and because any process that might lead to greater ability upon the part of the non-Anglo population to govern itself, is viewed as threatening.

(5) The lack of sophistication and powerlessness of the workers made them incapable of resisting the tactic. Many of them were fooled into thinking it was for real.

(6) The inability of the federal government to directly serve needy, but politically impotent consumers, without working through hostile local forces was a prime contributor to the debacle. Once again the people were mangled.

In contrast to Immokalee, Dade County was able to muster tremendous community support for the project. The Medical School, the County Medical Society, the Health Planning Council, the Urban Coalition and somewhat reluctantly and even truculantly, the local health department. The difference of course, is that Dade County is overwhelmingly urban and it is therefore possible to circumvent potential opposition from rural elements. This distinction between urban Dade

and rural Collier County while fortunate for the farmworkers in Dade is cause for the deepest melancholy in the remainder of the rural poor.

Nevertheless, the Dade County project does provide a laboratory in which we can observe a project that has on its board a majority of consumers. Hopefully, the clinic will not only provide first rate medical service but will also act as a training ground for community leaders. It is interesting to note that the principal source of discontent with consumer control in Dade County appeared to be the local Health Department and the regional federal bureaucracy in Atlanta. Perhaps with experience they will come to also cherish the values attendant upon consumer control.

I started these remarks by asserting that it is the farmworkers and not the protesting agribusiness men who are the victims of bias. The examples I have recited are merely a few among legions that support that statement. When the growers come in and lobby for workmen's compensation, unemployment insurance, grower responsibility for social security, more stringent housing codes, better health services a tenfold increase in housing starts with better terms; when they conduct voter registration drives, finance leadership clinics, provide better wages and financial incentives and really believe that the word "nigger" is bad, they will have established some credibility with the farmworkers and their friends. In short, when the growers believe in the American dream for the other guy—then their pleas will not have the hollow ring of hypocrisy.

Thank you, Chairman Mondale and the other distinguished Senators on the Committee for giving me this opportunity to express my views.

○