Dr. LEE. The leadership you and members of the subcommittee and full committee have provided in the field of migrant health has brought medical care to great numbers of Americans who might not otherwise have known any of the benefits of modern medicine.

Until passage of the Migrant Health Act in 1962, health care for migrants was virtually nonexistent. Today, thanks to extension of the act in 1965 and your continued support, major gains have been made in bringing health services to this group, who, in spite of their vital role in the agricultural industry, remain the last to receive health benefits most Americans take for granted.

The core provision of the act is the family health service clinic. At present, family health service clinics are operating seasonally or year round at more than 200 locations. The typical project places major emphasis on general medical care offered by private medical practitioners in family health service clinics, in out-patient departments of hospitals, or in their own offices.

Some projects provide dental services. All provide nurses who welcome incoming migrants, informing them of the services available to them. All provide sanitation workers and health education programs.

Hospitalization was added to the scope of service under the provisions of the 1965 extension of the Migrant Health Act. Funds became available for the first time for this purpose during 1967.

In the latest 12-month period for which summarized project data are available, migrants made 215,000 visits to physicians and 24,000 visits to dentists. In addition, nurses made 125,000 visits to migrant households and sanitarians made almost the same number of visits to living or work sites. Many communities and individuals have invested their own time, facilities, equipment, funds, and other items essential to the provision of project services.

The improvements which have been made in migrant health care since the passage of the act are quite dramatic, but there is still much to be done. Grant-assisted projects are reaching only about one-third of the Nation's migrants, and these for only part of the year.

Nearly 40 percent of the counties with seasonal migratory workers still have no grant-assisted project services. Medical visits and dental visits made by migrants are only about one-fifth and one twenty-fifth of the national per capita average. Deaths from influenza and pneumonia, tuberculosis and other infectious diseases, diseases of early infancy, and accidents are from 150 to 300 percent of the rates for the Nation as a whole.

Without continued and expanded financial and technical assistance, much of the current effort would be lost. The President's National Advisory Commission on Rural Poverty has recommended extension of the Migrant Health Act with sufficient funds to expand the program in terms of geographic coverage and services offered.

The advantages of a separate health program to migrant families have been great. But the time will come—and very shortly—when migrant families will be far better served by a recognition on the part of the States and communities that for all their unique problems and needs, migrant families are much like the rest of the population. They must have access to medical services at a price they can afford to pay.