Dr. LEE. As we develop, and as the States develop the capability for planning, the purpose, of course, of the partnership for health will continue to be to create a mechanism in the States and permit the States to set their own priorities. We then review that in relation to the priorities that have been set within the States; and certainly in terms of national needs and national priorities, those are also looked at as they relate to these State plans.

But we want to have the States make these determinations. And this, of course, presents unique problems with the migrants, because they do move from State to State, and it is difficult to encompass that within any single State plan.

Mr. ROGERS. Our time is running out. I would like to have a run-down on the migrant health programs, what is being done, how many people are being affected, and how many people are involved, and in what areas of the country.

(The following information was received by the committee:)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE STATEMENT ON MIGRANT HEALTH PROGRAM STATUS, MARCH 1968

Goal.—To improve the health status of migrants through improving their opportunities for health services and a healthful environment.

Guidelines.—

Help the migrant help himself.

Help communities recognize and assume responsibility for including migrants in total community health planning.

Promote adaptations of community services to migrants' needs and situation.

Establish continuity of care as people move.

Utilize fully all available resources.

Get migrants included in—not further isolated from—community life.

Status (see also attached directory (p. 88) and report (the PHS report, entitled "Migrant Health Programs—Current Operations and Additional Needs" has been placed in committee files)).—

115 single or multi-county projects are operating with migrant health grant assistance in 36 States and Puerto Rico.

285 project counties offer migrants personal health and sanitation services.

155 additional project counties provide sanitation services only.

More than 200 family health service clinics operate seasonally or year round.

1,000 physicians provide migrants medical care in the clinics, in their own offices and in hospitals.

300,000 migrant workers and famly dependents were in counties served by projects for at least part of 1967. They made—

215,000 medical visits; and

24,000 dental visits.

125,000 visits were made by nurses to migrant camps, other farm labor housing, and migrant schools and day care centers.

125,000 visits were made by project sanitarians and aides to home and work sites for inspection and follow-up.

$7.2 million—the total funds appropriated for grants—was obligated in 1967 and tentative commitments for continued grant support were made at the same level. Most projects have submitted expanded requests for continued grant support. These requests could not be met since the 1968 appropriation was the same as that in 1967. In each year since the program started the total amount available for grants has been obligated and approved projects have had to be carried to the next year.

Hospital Component (As of January 1968).—

55 of the 115 grant-assisted projects have hospital service components. These projects are located in 25 States.

162 hospitals have signed agreements with projects to provide migrants hospital care.