mimi

Si Se Puede: A Policy Brief With Recommendations to Improve Access to Health Care for California's Farm Workers

DISCUSSION DRAFT

SÍ SE PUEDE

A POLICY BRIEF WITH RECOMMENDATIONS

to

IMPROVE ACCESS TO HEALTH CARE FOR CALIFORNIA'S FARM WORKERS

Interim Farm Worker Health Task Force

California Program on Access to Care
California Policy Research Center
University of California
1950 Addison Street, suite 202
Berkeley, CA 94704-1182

December 30, 1999

@ Pol Research Ctr.
510-643-3140

INTRODUCTION

The emergence of California's Latino population as a voting constituency provides the state's agricultural work force with unprecedented leverage to rectify decades of neglect in state policy and programs. Farm worker health and health care are particularly pressing areas of need. A Symposium sponsored by the California Program on Access to Care in the California Policy Research Center of the University of California (CPAC/UC) convened a large group of researchers, activists and state policy-makers on September 16th and 17th, 1999 to develop a common framework for pursuit of change.

Purpose, Contents, and Use of the Policy Brief

A major recommendation of the Symposium participants was that CPAC/UC establish an interim Farm Worker Health Task Force with appropriate geographic, programmatic and financing expertise to develop and report on the findings of the Symposium. The Task Force was formed in November 1999, and this brief presents its synthesis of findings and policy recommendations to date. A list of the members of the Task Force is attached.

This policy brief provides an objective record of the CPAC/UC Symposium. It condenses the complete transcript and associated papers from the Symposium into a Summary of Findings and Recommendations. It also contains selected direct quotations from speakers, panelists and participants to convey some flavor of the proceedings. The quotations are attributed to the individuals who made them.

It is important to note that this brief is intended to be the start of a continuing dialogue and effort to improve access to care for farm workers in California. It is not intended to be a comprehensive discussion of all of the needed policy revisions to improve access to health care for farm workers. Moreover, it is the hope and intent of the Task Force that the brief will generate further discussion of the issues and that the Task Force will continue to refine and update the recommendations outlined below.

This policy brief will be circulated to policymakers, funders, advocates, and providers for their information and to begin to guide and influence policy development for farm worker health in the year 2000 and beyond.

The intent of the Task Force in issuing this document is to provide guidance and recommendations to improve health care access for all farm workers and their families in California, regardless of age, ethnicity, gender, level of income or immigration status.

CPAC/UC wishes to thank consultant Lucy Johns of San Francisco for her work in writing and editing the initial drafts of the Policy Brief.

Symposium Program and Participants

The full-day Symposium presented speakers and panels addressing a variety of factors important for understanding and changing the health of farm workers and their access to care. Presenters and moderators (in order of presentation) included:

Ruth Covell, MD, UCSD School of Medicine and Chair, CPAC/UC Advisory Committee
George B. (Peter) Abbott, MD, California Department of Health Services
Dolores Huerta, United Farm Workers Union
Bonnie Bade, California State University-San Marcos
Bobbie Ryder, National Center for Farmworker Health
David Hayes-Bautista, UCLA
Kathryn Azevedo, UC Irvine
Elia V. Gallardo, California Primary Care Association
Ed Mendoza, California Office of Statewide Health Planning and Development
Refugio I. Rochín, Smithsonian Institution
Mario Gutiérrez, The California Endowment
Janet Coffman, Center for the Health Professions, UCSF
Luisa Buada, California Institute for Rural Health Management
Michael Koch, California Kids
Catherine Camacho, California Department of Health Services
Robert O. Valdez, UCLA School of Public Health
Andrew Alvarado, UCSF/Fresno
John Blossom, MD, UCSF/Fresno
Hon. Debra Ortiz, California Senate
Saeed Ali, California Latino Legislative Caucus
Gilbert Ojeda, CPAC/UC

The Symposium was attended by 111 people.

CPRC/CPAC Technical staff that participated in the symposium and in the preparation of this report are:

Gilbert Ojeda, CPAC Project Director
Susan Carter, J.D., CPAC Project Manager
Jaime Garcia, CPAC Analyst
Lucy Johns, M.P.H., Private consultant, San Francisco

SÍ SE PUEDE

A POLICY BRIEF WITH RECOMMENDATIONS TO IMPROVE ACCESS TO HEALTH CARE FOR CALIFORNIA'S FARM WORKERS

EXECUTIVE SUMMARY

"We as a nation enjoy the lowest food cost per capita of any industrialized nation....We do it because we have a severe dependence on cheap labor. We do it on the backs of the farm workers..." (B.Ryder)

California outranks all other states in the overall farm revenues of agricultural products as seen in last year's crop values at nearly 28 billion dollars. Six out of the seven most agriculturally productive counties in the United States are located in the Central/San Joaquin Valley with Fresno and Tulare Counties leading all others. While this bountiful productivity contributes to the overall economic well-being of the state, the nature of many of the state's 300 crops requires a substantial labor intensive workforce force during peak periods that may last from several weeks to several months. This labor force is essential in the state's high productivity of food and fiber that is distributed both nationwide and exported to foreign markets. Without the efforts of farmworkers, it would not be possible to support the multi-billion dollar fruit and vegetable industry in California and, indeed, in the nation.

Despite this critical role that farm workers play in California's economy, they live and work under conditions that have not improved, and may in fact have worsened in at least twenty-five years. The economic status of farm workers is vividly obvious in many agricultural rural communities throughout the state and in the Central Valley in particular, where these communities resemble developing third world villages more than they do "country life" images of California living.

California's farm workers employed in production agriculture are exposed to occupational health hazards and suffer job-related injuries, illnesses and accidents at rates that exceed virtually all other occupational groups. Farm workers are also among the most impoverished of all occupational groups, are seldom enrolled in employer contributed private health insurance programs, and frequently fail to qualify for federal-state financed health care services. The low wages and earnings of this workforce preclude any meaningful contributions into health insurance programs by the workers for themselves and their families.

KEY FINDINGS

- The size of the farm worker health problem is not easy to measure, nor is the level of deprivation of health services. Available statistics suggest that both are substantial, with the total farm worker and family population estimated at 820,000-1.25 million and medical service areas heavily populated by farm workers often designated "medically underserved." (Section 2)

- The size and lack of access to health care of the farm worker population contrast with the wealth of the industry their labor sustains. California agricultural commodities yielded $26.8 billion in receipts in 1997. (Section 2)

- Health problems faced by California's farm workers, which result from unique barriers as well as risk factors common to other poor and rural groups, present an urgent policy challenge. (Section 1)

- Barriers to access and improvement of health that are unique to farm workers include: immigrant status; exposure to extreme occupational hazards (toxic substances, strenuous physical labor in high heat, job-related injury); high mobility associated with farm employment; multiple employers per year; and widespread illiteracy. (Section 1)

- Farm worker demographics, dominated by the "young, Mexican, male" stereotype, actually show a pervasive family structure, increasing ethnic diversity and aging of non-migrant workers. Most California farm workers live in families. (Section 3)

- Farm workers are desperately poor with median family income at $5,000-7,000 per year. (Section 3)

- Poverty among farm workers and their families results from: very low wages, employment often less than half the year, high seasonal unemployment, no job security or unemployment insurance. Many work five or more jobs per year. (Section 3)

- Housing for farm workers and their families is commonly abysmal, with severe overcrowding and frequent unsanitary conditions. This situation contributes to the health problems faced by farm workers. (Section 3).

- The vast majority of farmworkers have no private health insurance coverage. A number of barriers severely limit access of farmworkers and their families to public insurance programs, such as Healthy Families, Medi-Cal and Medicaid. (Sections 3 and 9).

- Farm worker health status presents a complex picture that includes some better health indicators than might be expected (e.g. birth outcomes), growing evidence of unmet need (e.g. mental health, substance abuse, diabetes), occupational hazards and reports of culturally-sensitive problems (e.g. widespread domestic violence). (Section 4)

- A historic strategy for improving farm worker health is unionization, which has included health insurance as a negotiated benefit and workers' compensation as state policy in California, as well as some preventive health activities and pressure to modify workplace health risks. Unionization is not widespread, however, (Section 5)

- The recent establishment of large foundations from health facility and health plan conversions, coupled with the rising influence of Latinos throughout state government and the foundation community, enable current strategies directing major new resources to improvement of farm worker health and access. Examples include: CaliforniaKids Healthcare Foundation; increased funding for Department of Health Services' support for clinics and rural health; the Rural Demonstration Projects in the Health Families Program; major investments by The California Endowment and the Irvine Foundation; and the non-profit network Radio Bilingüe. (Section 6)

- The Symposium highlighted a number of critically needed future strategies to improve farm workers' access to care. New efforts should be initiated in the areas of health research, restructuring of federal and state policies that inhibit farm worker access to care, health workforce development and provision of additional support for community health clinics. (Sections 7 and 9)

- Information and strategies will more likely influence policy-making if presented with an understanding of the political context surrounding farm worker issues, including health. The context grows increasingly positive as Latino and Central Valley legislators and state officials become more numerous and prominent. (Section 8).

Policy Strategies to Improve the Health of California's Farm Workers

Based upon the above key findings, participants at the Symposium outlined a number of policy strategies that should be implemented to improve the health of farm workers and their families in California. The Task Force strongly endorses the implementation of these policies, and found that the following recommended policy revisions were of the most immediate importance and priority:

I. Refinement of Current State Policy

1. **Revise the Medi-Cal and the Healthy Families Programs to accommodate farm worker realities**, including but not limited to:

(a) Provide children in Medi-Cal a full year of continuous coverage and eliminate quarterly reporting.

(b) Provide portable Medi-Cal coverage to eligible migrant farmworker families.

(c) Target Medi-Cal and Healthy Families outreach efforts to enroll eligible farmworker families.

(d) Broaden eligibility criteria consistent with allowable federal guidelines, including possible waiver requests.

(e) Reduce the length of application and continue to streamline the application process for Medi-Cal and Healthy Families.

(f) Offer presumptive eligibility for children of farmworkers. The State can take up to 45 days to process a Medi-Cal application, forcing many children of farmworkers to wait for critical services. Presumptive eligibility would enable children who are likely to be eligible to receive care without delay.

(g) Revise share-of-cost requirements in Medi-Cal to take into account the seasonal nature of farm work.

(h) Establish pilot projects to test the feasibility of expanding eligibility and enhancing federal financial participation through the Medi-Cal program.

2. Adapt education in the health professions to finance and reward training and practice suited to farm worker and rural conditions, including but not limited to:

(a) Promote access to medical schools for youth from farm worker families and rural communities who will return to practice in those communities.

(b) Urge the state's medical and nursing schools, particularly public institutions, to acknowledge the health needs of underserved Californians within their missions. Financial support to meet the health care needs of farm workers and other rural indigents should follow this mission expansion. Explore the use of GME reimbursement dollars to provide such incentives.

(c) Expand the existing National Health Service State Loan Repayment Program and target placements to sites that serve farm workers.

(d) Encourage and provide incentives for greater involvement of universities and colleges located in rural regions of the state in health issues associated with those regions.

3. Strengthen the Community Clinic System.

(a) Increase the number of clinics in farm worker areas where services are largely or totally absent.

(b) Augment funding to farm worker clinics offering urgent care, week-end and extended hours to farm workers.

(c) Target State Rural Health Services small grants and Rural Health Development Grants to reach more farm worker health care providers.

4. Assure that the California Department of Pesticide Enforcement improve enforcement of pesticide regulations.

II. New State Policy Initiatives

1. **Create new funds through targeted taxes such as a tobacco, alcohol, or a "best food commodity tax" that would be targeted for farm worker health problems.**

2. **Target new state general fund base funding to farm worker health programs.**

3. **Create a campaign to raise awareness of the value and benefits of agricultural production to California including the contributions and hardships of farm workers.**

4. **Develop and fund health workforce initiatives, including "pipelines" (K-12 school systems, community colleges and baccalaureate granting colleges) to recruit and assist students who are likely to complete health professional training and practice in farm worker areas; a statewide strategy to identify, develop, and support clinical sites for the training of health care professionals to provide services to the farm worker population; and statewide criteria for**

academic accreditation of rural training sites that offer experiences in farm worker health care to health professions students.

5. Monitor farm worker health status and evaluate the impact and outcome of new and existing programs and services by conducting comprehensive assessments of the health outcomes for this population.

III. Federal Health Policy

1. Coordinate, streamline, integrate, and maximize the allocation of disparate funding sources for farm worker health services.

2. Ensure that the Year 2000 census accurately enumerates the farm worker population.

3. Urge revision of Medicaid regulations to reduce barriers to the immigrant and farmworker populations.

IV. Public Health and Prevention

1. Create new resources and supplement existing resources for the development of housing for unaccompanied male farm workers and for farm worker families.

2. Conduct a statewide assessment of the needs and resources in farm worker health to guide appropriate interventions, prioritization and evaluation.

SUMMARY OF FINDINGS

1. FARM WORKERS: A SPECIAL CASE

Health problems faced by California's farm workers present an urgent policy challenge. They result from unique barriers, as well as risk factors common to other poor and rural groups. Like other poor residents of the state, farm workers suffer from:

"(H)ow to improve, not only the health of California's farm workers, but also...an inseparable issue, which is, how to address health issues of California's rural populatic (P. Abbott)

- extremely low incomes;
- poor housing;
- unsanitary and unsafe living conditions;
- insufficient income to attract and keep medical practitioners;
- lack of knowledge of available programs;
- confusion and fear in the face of complex access procedures (eligibility; applications);
- language and cultural competency problems of providers;
- non-portability of coverage when moving from county to county.

Farm workers also face risks familiar to rural residents:

- geographic isolation;
- lack of transportation;
- lack of phone services.

Compounding these generic risks are barriers to access and improvement of health that are virtually unique to farm workers. These include:

- immigrant status;
- exposure to extreme occupational hazards involving toxic substances, strenuous physical labor in high heat, and job-related injury;
- high mobility associated with farm employment;
- multiple employers per year and lifetime;
- widespread illiteracy.

This multiplicity of risks and barriers implies a need for policy initiatives tailored to the complex health problems of California's farm workers.

2. THE SIZE OF THE PROBLEM

The size of the farm worker health problem is not easy to specify, nor is the level of medical deprivation. Available statistics suggest that both are substantial.[1] Thus:

"hired farm worker MSSAs have the poorest access to health care services of all California communities." (D.Villarejo)

- In 1990, nearly four million people resided in California's 210 rural Medical Service Study Areas (MSSAs).[2]
- Forty rural MSSAs are "medically underserved."[3]
- Over half of "medically underserved" rural MSSAs (23) have a high concentration of farm workers. Of the five most "medically underserved" areas in the state, four are "hired farmworker"[4] MSSAs.
- About nine percent of rural households lack telephones, rising to 20 percent in a few areas.
- The number of farm workers and their families in California is unknown. Estimates of farm workers vary from 470,000-900,000; adjustment for family members yields a total of 820,000-1.25 million[5] target population for farm worker health policy.
- More than half of California's farm workers are legal residents, but over 40 percent are undocumented.

The size and lack of access of the farm worker population contrasts noticeably with the wealth of the industry their labor sustains. California agricultural commodities yielded $26.8 billion in receipts in 1997, more than three times the box office receipts of the motion picture industry and more than twice the value of farm products produced by the next two states combined.

3. FARM WORKER DEMOGRAPHICS

"(W)hen we think of farm workers, really what we need to think of are families." (B.Bade)

Farm workers are overwhelmingly male (82 percent), relatively young (median age=30), predominantly foreign-born (91 percent), and frequently illiterate (67 percent).[6] Beyond this "young male" stereotype, however, is a pervasive family structure[7]:

- 45 percent of farm workers have families with them;
- 61 percent are married and 56 percent are parents;
- many older farm workers have families in Mexico;
- many farm worker families are split between California and Mexico.

An emerging feature of farm worker families is a growing diversity of origin. Stereotyped as "Mexican," workers increasingly consist of indigenous people from southern Mexico (who may speak Mixtec or Zapotec or Triqui) and peoples from Central America.

A common feature of farm worker family structure that can influence health status of individuals and entire families is the diverse legal status among members of the same family, for example:

- one member may be legal, the others not;
- one member may have some insurance, the others not;
- one child may be eligible for MediCal or Healthy Families, others not.

The net result is avoidance: the system is too confusing, too time-consuming, too arbitrary to access health care unless faced with a stark emergency.

Farm workers are desperately poor.[8] Median family income is $5,000-$7,000 per year; 61 percent live below the federal poverty rate and 75 percent earn less than $10,000. On average, seasonal unemployment is very high and work is available only half of the year in labor-intensive fruit and vegetable fields for $5.27-5.69 per hour. There is no job security and no unemployment insurance. Thirty percent work five or more jobs per year. Twenty percent own no assets, not even a car.

Housing is commonly abysmal, with severe overcrowding and frequently unsanitary conditions. Actions by county officials to enforce environmental regulations or housing codes can sometimes make poor housing conditions worse. For example, farm workers living in squalid trailer parks have been observed to relocate to Native American lands, where sanitation and utility connections are entirely unregulated.[9]

Consistent with their poverty and occupation, only about one-third of farm workers have any health insurance, even fewer use Medi-Cal, and this only for deliveries and very sick children. [10]

"In the last 20 years, we've seen increasing diversity of the farm worker population... (bringing) distinct cultural forms, their own languages,...different concepts of illness and treatment." (B.Bade)

"I saw...as a 14-year old worker in the field that my paycheck was identical to (my father's), and he'd been doing that all his life...And it really struck a note with me...that I was making as much as a man who had to support a family of six." (A.Alvarado)

"(We) opened our [clinic] doors [in the 1960s] and nobody came. (So) we...visited people...and it became strikingly clear why they weren't coming. Because the last thing on their list of priorities was...getting medical care...(J)ust basic food, living conditions, and survival...only (at) a very delayed point, when the pain couldn't be sustained any longer, (did) they seek care." (M.Guitiérrez)

"So now you have people ...in unregulated trailer parks and they're really suffering from poor sewage, contaminated water, open pools of water festering with insects, incorrect electrical connections, no water run-off, improperly installed propane tanks." (K.Azevedo)

4. FARM WORKER HEALTH STATUS

Despite their poverty and large numbers, no comprehensive data on farm workers' health exist. Information[11] gleaned from a variety of sources presents a complex picture. Some statistics suggest better health than might be expected. Others provide clear evidence of unmet need. Culturally-sensitive health problems were also reported by Symposium participants.

"(E)mergency and pregnancy-related care is available, but chronic illness - asthma, arthritis, diabetes, high cholesterol - and acute illness - fever, diarrhea, infection... are either untreated or self-treated with traditional means..." (B.Bade)

On the positive side:

- Birth outcomes are excellent, although this trend worsens somewhat among succeeding generations of American-born Latinas.
- Incidence and mortality from cancer and respiratory disease are lower than average, perhaps due to low prevalence of tobacco use.

On the negative side:

- Use of clinical health services is low, is concentrated on maternity and emergency care, is typically sought late in the course of both pregnancy and illness.
- Stress-related mental health problems, substance abuse, sexually-transmitted disease, gambling, and homicide are prevalent.
- Diabetes is of increasing concern.
- Seventy-one percent of children in one community were found to need referral for one or more adverse condition, especially vision, dental and incomplete immunizations.

"Stress and mental health problems are among the less-recognized health issues likely to be faced by hired farm workers." (D.Villarejo)

Domestic violence is also a major problem noted by Symposium participants. It is said to originate in the "culture of machismo" and is exacerbated by use of alcohol.

Another perspective on farm worker health status comes from an ethnographic study of health problems self-identified by a diverse group of women. Over ten percent of one small sample report: *coraje* (anger), *susto* (fright), and *empacho* (indigestion). The symptoms reflecting these conditions vary.

"(An) area that we need to just drag...out of the closet (is) domestic violence. (I)t's very prevalent...We interview...female parents and their number one need and concern was dealing with domestic violence fueled by alcoholism and alcohol." (S.Villon)

Farm worker health status is affected by an environment of high risk and adverse conditions. Agriculture is the most dangerous industry in the country, with a mortality rate in California of 17 per 100,000 workers (more than three times other industries except construction), even with widespread suspected underreporting. Exposure to toxic pesticides is the norm. The housing shortage is drastic; makeshift "back houses"

are common, even for year-round residents.[12] An unhealthy water supply is widespread.

5. A HISTORIC STRATEGY FOR IMPROVING FARM WORKER HEALTH: UNIONIZATION

Delores Huerta, co-founder and Secretary-Treasurer of the legendary United Farm Workers (UFW), described the effects of unionization on access to health services. These include: eligibility for workers' compensation and disability insurance, direct provision of services, and health insurance coverage. The last is provided by UFW to its 27,000 members in three states through its Robert F. Kennedy medical plan. An ERISA[13] plan administered by the UFW and employer representatives, it accommodates some insistent realities of farm worker life, thus:

"This is all really wonderful but you know it has been earned at such great cost, because we still have a lot of opposition out there by the employer community to the unionization of farm workers...We've had five people killed. Our last martyr was a 21-year-old...killed in Fresno...because he organized his ranch to have a union." (D. Huerta)

- It covers only major medical, maternity, vision, and dental care, as well as a small death benefit.
- Maternity and death benefits can be accessed outside the US, thereby covering family members not residing in the United States.
- Where the union does not have a contract, farm workers can become "associate members" of UFW for $30 per year and can join the medical plan for only $360 per year.
- Services are delivered through a preferred provider network.
- The plan is coordinated with the national health insurance system in Mexico.
- The plan is financed entirely by the employer.

"(I)t's not enough to be politically aware. We've got to be politically active...We've got to get people into the legislatures and into the Congress that will really support our issues...(W)e are in a very good position now...So we have to really...take advantage of this..." (D.Huerta)

Other UFW activities to promote farm worker health include:

- outreach for infectious disease screening and prevention;
- vigilance on the pesticide issue;
- a pension plan.

Knowing the limits of its health-related work, the UFW also works against poverty, fear among undocumented farm workers, harassment, and racism. An essential UFW activity is thus involvement in legislative activity at both federal and state levels. In Washington, UFW presses for amnesty for undocumented workers and for transportation initiatives that will bypass the notorious labor contractors (*directeros*). In Sacramento, it is concerned about paycheck deductions for medical benefits, a great burden for low-income families.

Everywhere, it supports national health care.

The UFW also seeks allies. Ms. Huerta appealed to the Symposium participants to work with the UFW and assured them that her Executive Board is eager to work them.

"Sí se puede." (All)

6. CURRENT STRATEGIES TO IMPROVE ACCESS FOR FARM WORKERS

The recent establishment of large foundations from health facility and health plan conversions, coupled with the rising influence of Latinos throughout state government and the foundation community, provides important new resources directed to services for farm workers. Examples include:

"(P)hilanthropic support is not the answer. We have to work at insuring these kids...(P)eople who start these models...aren't necessarily the ones...to sustain it." (M.Koch)

CaliforniaKids Healthcare Foundation: Private, comprehensive (includes dental, vision, drugs, behavioral, nurse hotline) insurance for children 2-19 in families at 100-200 percent of federal poverty level. Premiums - under $400 per year - paid by philanthropic gifts. Services provided through PPO networks. Since its founding in 1992, 18,000 children served, including farm workers' children referred through the state Migrant Education program (about half the total). Positive outcomes include increased self-esteem among children and productivity among parents. Problems include: low use of dental and vision (despite no co-pay); physicians jumping medical groups; dependence on philanthropy. Current target population is children ineligible for Healthy Families.

"(F)or $350 or $400 a year...there's enough money in this room...to insure every single child." (M.Koch)

California Department of Health Services (DHS): Financing for rural area clinics, in FY 1995-96 under $1 million, is now $6.2 million, an increase due in large part to participants in the Symposium. Existing migrant worker clinics will get 40 percent of a $5 million "augmentation" that raises the "baseline" budget for clinics. Proposals for additional clinics will be sought in early 2000. California Children's Services (CCS) and CHDP also serve farm workers' children, although numbers served are not known. WIC serves 10,000 families a month.

"How many additional farm workers can you serve with the additional ($2 million)...I want to know how many additional families?" (S.Ali) "I can't tell you." (C.Camacho)

Rural Demonstration Projects in the Healthy Families Program: California is the only state targeting farm workers in the federal child health insurance program (Healthy Families). Administered by both DHS and the Managed Risk Medical Insurance Board (MRMIB), $9 million (over three years) was awarded in 1999 to 57 proposals to increase numbers and mix

of personnel, enable capital improvements and strengthen infrastructure.

The California Endowment: farm worker health is a high funding priority among the almost $2 billion in distributions issued over a seven year period, including: a "landmark" Rural Community Assistance Corporation to link health and housing,[14] partnership with the state's County Medical Services Program to promote wellness and prevention in rural areas and strengthening public health departments throughout California through the Public Health Institute.

The Irvine Foundation: through its Institute for Rural Health Management, promotion[15] of rural, integrated health systems in four areas: Imperial County, Humboldt-Del Norte, Ridgecrest (Kern County) and Lompoc (Santa Barbara County).

Radio Bilingüe: a California-based, non-profit, Latino organization that produces, distributes and broadcasts radio (and soon website) programs throughout the US, including Puerto Rico and Mexico. In partnership with state and federal agencies and private foundations, it provides substantial health programming known to reach many Latinos, particularly mobile populations.

"In...Imperial County...[the Institute for Rural Health Management] got a lot of resistance...it took... nine months (but) we got everyone to sit at the table... (They) looked at data for the first time ...And as a result..., a number of successful collaborations:... injury and illness prevention grant...the Irrigation District (and) the Health Department working...on TB prevention." (L.Buada)

"...(L)iteracy is such a big, big issue when it comes to reaching this population [farm workers]..." (H.Morales)

"Most of the norteño songs...being played [on commercial radio] in Spanish are actually promoting drugs and violence. It's sad." (H.Morales)

7. FUTURE STRATEGIES FOR IMPROVING FARM WORKERS' ACCESS TO CARE

The Symposium highlighted several strategies that could improve farm workers' access to care in the future. These fall into the policy areas of:

- health workforce development;
- restructuring of health clinics;
- health research; and
- a more comprehensive health policy framework.

"(It's) 20 years later (and) we're no further along. In fact, in many instances we've actually gone backwards...We're really not moving." (V. Huerta)

Strategies discussed in each of these areas include:

"We're asking that the educational institutions consider themselves to be instruments of social change." (J.Blossom)

Health workforce development: Key here is creation of a "supply pipeline" of linguistically accessible, culturally compatible, ethnically diverse practitioners. Latino physicians now comprise only four percent of California physicians. Pipeline strategies include:

- **recruitment** of applicants from underserved communities (who will presumably return);

"We need to direct resources to improve overall medical education in California. Now I know that the Central Valley has done a remarkable job but there are areas in northern California and the southeastern desert region which we really have no relationship with the UC medical schools, the community migrant health

- **immersion** in underserved areas during clinical training; and
- **support for practice** in underserved areas.

Recruitment implies working with rural school districts from grades K-12, in turn requiring unprecedented infusions of financial and technical resources. Immersion is already occurring for family practice residents at UCSF/Fresno and UC Davis, but is unknown in other areas of the state. Practice support must go beyond assistance with repayment of loans for education (now done through the National Health Service Corps, administered in California by OSHPD). It must address: payment for services when patients have no means no pay; daycare for children of young physicians; housing for part-time location; and linkages to professional resources. Finally, a "supply pipeline" needs supplementation of faculty practice revenue for faculty who will work in underserved areas, but who cannot generate clinical income from impoverished patients.

Another workforce strategy is to integrate clinical medicine more closely with farm worker culture. One way is to utilize *promotores*, health workers from the community, who can link its members to clinical resources. Trained *promotores* are observed to make a difference for accessing "biomedicine" in a timely manner. Another is to build on the practice of traditional healers - mothers, healers, and pharmacy owners - who treat *coraje, susto, empacho* with herbs, ritual, and sweat baths.

Migrant Health clinics: Although not addressed directly by Symposium speakers, migrant worker clinics generated some comments from participants. There is concern that funding is an issue, particularly since the federal allocations are not on a per capita basis and thus do not reflect the very high number of migrant workers in California.

Health research: The ideal strategy here would be institutionalization of a statewide survey of farm worker health. Two proxy studies by University of California researchers were featured at the Symposium. Proxy studies constitute a strategy for change because they can provide enough data and raise enough questions to prompt policy responses.

The first proxy study used zip code analysis to infer health status and use of services by farm workers, who are not explicitly identified in large health data sets. These characteristics, inferred for the population in 43 zip codes where 40 percent or more of people worked in agriculture according to 1990 census data, were then compared with those of non-farm zip codes. Among the insights from this approach are the following:

centers, have no medical students, no medical residents, no nurse practitioners who are students...." (K.Azevedo)

"(B)ringing clinics...and residency programs together...has been a complete misunderstanding. ..(B)asically, it amounts to money and...to the lack of support...both on the state and the federal level. (C)linics unto themselves are not able to support residency programs." (V.Huerta)

"Mothers in farm worker families are primary care physicians, they literally are. And traditional healers are working daily...with farm worker health. So a cultural exchange program between biomedical and traditional ...providers will be beneficial to both sides." (B.Bade)

"I'm seeing...a real tension in the mission of (migrant worker clinics) as they try to remain financially viable... responding to changing funding streams...it's changing the characteristics of these institutions and I think it needs to be looked at." (A participant).

"(Y)ou know, we have susto, we have empacho, we have all these kinds of things, but (this isn't) because people choose to do those things,...it's a fallback because they have no access... it's not necessarily because it's a religious or cultural belief. It's an alternative to what's not available to the them.." (V. Huerta)

"(T)he humbling part of all this is to realize how much we don't know and how much we need to know...if we want to effect some policy." (D.Hayes-Bautista)

- Pregnancy experience differs markedly between populations in farm worker vs. non-farm worker zip codes. Latino births far outnumber any others; mothers are much less educated; prenatal care in the first trimester is much lower; teen births are higher; Medi-Cal payment is much higher.
- Low birthweight birth outcomes are much lower than would be expected in farm worker zip codes.
- Mortality experience also differs strikingly: motor vehicle accidents are the first cause of death among persons age 25-44 in farm worker zip codes, three times the non-farm zip code rate; unintentional injury rates are higher, while homicide rates are actually somewhat lower for farm worker vs. non-farm worker zip codes.
- Mortality experience in the 45-64 age group shows cardiac mortality in farm worker zip codes higher than a comparison of US-wide Latino and non-Latino rates would predict, and this is also true for diabetes, stroke and cirrhosis.
- Hospitalization experience also shows sharp contrasts, farm worker vs. non-farm worker zips: mental health discharges are far lower; Medi-Cal discharges are far higher; length of stay is shorter, even for 45-64 age discharges when short birth stays no longer dominate.

"(S)tudies should be done ...about the relationship between the type of work that farm workers do [and cause of death] and when I'm talking about work, I'm talking about the piece rate...(W)orkers have to work at such a rapid pace...as the farm workers get older, they've got to try to keep up with the younger...and it's very difficult for them...many of the farm workers dye their hair so they'll get hired." (D.Huerta)

The second proxy study used non-probability "cluster sampling" to study 130 households in two areas, one each in northern and southern California. While this sample is acknowledged to be "unique...not typical of all farm workers,"[16] it reveals some suggestive data, as follows:

"(M)edical care...isn't the single most important influence (on) health. [We] need move into a population health perspective...really identify what are the most prevalent conditions... (and) translate (them) into much more proactive, community-based public health, population-based interventions." (K.Grumbach)

- The burden of disease between migrating and non-migrating farm workers does not differ, despite somewhat better living conditions for the non-migrating workers.
- Although about 60 percent of families had some type of health insurance, utilization of services is low, despite the proximity of primary care clinics.
- Despite availability of some coverage, significant barriers to use intervene: no dependent coverage, high deductibles, non-portability of Medi-Cal and HMO membership, quarterly re-certification for Medi-Cal, varying coverage among family members, the "public charge" issue, conflicting eligibility criteria in public programs and ever-changing rules.
- A paradoxical development is full coverage for care in Mexico only, inhibiting use by undocumented workers who fear inability to return, and for workers far from the border.

"I go into farm workers homes and I see them giving kids sodas for breakfast and I just shudder...(T)hey have no concept of why this [poor nutrition] is dangerous to their health...(W)e need to do an incredible, incredible campaign...a campaign on nutrition." (D.Huerta)

"(W)ork force initiatives are not enough...that ought to be obvious... (when) the challenges that people face have to do with housing, domestic violence, issues that go beyond the clinical care setting." (J.Coffman)

In response to these research presentations, several participants noted additional work being done, possible sources of data and observations of disease burden, thus:

- The California Institute for Rural Studies (Davis) with funding from The California Endowment, is conducting a comprehensive assessment (interviews and examinations) of health risks, needs, and access of farm workers in all six agricultural regions of the state.
- Outpatient clinics in Santa Barbara are being studied for actual farm worker health problems and use of services by UCLA-Center for the Study of Latina Health (CESCLA).
- Pesticide exposure is under study in the central coast by UCLA-CESCLA.
- Childhood leukemia is under study at UCSF/Fresno among a largely Latino population.
- UFW insurance data show heart disease to be the leading cause of death. This could be related to piece-work payment, which compels older workers to keep pace to compete with younger workers for jobs.
- UFW data also show high rates of back injury, especially among strawberry workers, as well as cancers believed associated with pesticide exposure.
- The National Agricultural Workers Survey contains a health supplement, which will be national in scope but California data will be a large component, perhaps separable. Results from this survey should be available by the end of the year.

"(F)arm workers need to be taught... a safe way to work...(F)arm workers that are in their 50s (are) stooped...all bent over...it's very heartbreaking...But the Filipino workers (have) a whole different system... (T)hey could work all day without having any backache, right? So we had one of the Filipino brothers come and do that education." (D.Huerta)

Health Policy Framework: While the Symposium's focus was access to medical care, it was noted by many that farm worker health status can be improved by interventions outside conventional medical care. Financial access is critical, but there is "no simple answer" to increasing access or improving health.[17] A "multi-factorial" approach is required.

Examples of this type of thinking included:

- health education concerning nutrition, a risk factor for diabetes;
- more emphasis on occupational health and safety;
- more enforcement of existing law relating to housing and vehicle safety.

From a "multiple determinants" perspective for improving health,[18] it was clear that a number of factors relate to health status among farm workers. Income is a well-documented predictor of health status: a study recently presented to the Latino Legislative Caucus estimated a median salary for

California Latinos of $14,560, $9-12,500 lower than other ethnic groups. This study attributed that gap to lack of education, since nearly 50 percent of Latinos have less than a high school education. Education, also a well-documented correlate of high health status (not to mention insurance coverage), is the "number one priority" of this researcher.[19] Another insight revealed by study of "the Mexicanization" of rural California is that "white flight" accompanies increases in immigrant populations, resulting not in loss of jobs (whites had them anyway), but in loss of income to local Latinos because job-related income is reported and spent elsewhere. Thus poverty, a major predictor of poor health status, may grow not so much with influx of immigrants as outflow of employed white residents.

8. THE POLITICS OF POLICY CHANGE

Information and strategies, no matter how well formulated, will more likely influence policy-making if presented with an understanding of the current political context. The comments of some experienced Sacramento players illuminated this context with respect to farm worker issues, thus:

- Policy proposals to the Legislature must include financial implications: costs, anticipated savings, cost-benefit analysis, return on investment.
- The state budget cycle is a critical variable for policy change, so proposals requiring financing must be tied to the Governor's budget or risk excision or veto in the final round.
- Rivalry between urban and rural legislators over distribution of scarce resources affects any debate on farm worker health, although the standing of legislators from agricultural districts is rising.
- A perception that legislators from the Central Valley increasingly constitute a "swing vote" regardless of party works in favor of farm worker issues, especially within an administration somewhat disinclined to create new programs or financially expand existing ones.
- Population growth in the Central Valley is one basis for change in politics and structures that affect farm workers.
- Proposition 209 is a barrier to recruitment and training of a linguistically and culturally competent workforce, as is concerns by the University of California to legislative

"(W)e're in a very good position now...(W)e have new Latino voting power. We have...a very strong Latino caucus that cares about the health of farm workers." (D. Huerta)

"I don't know if it's simply...the presence of Latino legislators, but there is clearly a far greater recognition and respect...among the members...from agricultural districts for the work of farm workers." (D.Ortiz)

"(A)s we hear great public policy...many will ask what does it cost, number one, and then many of us will counter and say, well, it's a long-term cost saving by investing, etc...So many debates will start and end with fiscal implications." (D.Ortiz)

"(W)e have shown over and over and over again... recruitment...from underserved areas and (the) likelihood

directives concerning their students and curricula.

- Effective advocacy includes prioritization (there are always more needs than there are funds to meet them) and accountability for results of increased support (migrant worker clinic audits show persistent deficiencies).
- The Center for Health Statistics, now accessible on the DHS website (www.dhs.ca.gov), provides user-friendly statistics and reports that can assist in research and policy development.

Farm worker health policy can also be furthered through linkages with related policy areas. Examples include agricultural, water, labor, and immigration policy. All involve complex federal/state relationships and incentives that ultimately affect farm workers' lives. All thus offer opportunities for intervention. When farm worker benefits can be created within these well-established government functions, change can happen rather quickly. A recent example is disaster relief during the Central Valley citrus freeze in 1998-99, which acknowledged "economic harm" and provided significant relief for both farmers and farm workers.

Another potential linkage is rural health policy in California. There is a vehicle, the County Medical Services Program (CMSP), and there is both state and foundation funding for CMSP to enhance health resources in the 34 rural counties (pop. <300,000) it serves. Duplication among migrant, Indian Health, and primary care clinics in rural areas creates inefficiencies whose elimination could increase resources for all. Application of information technology to rural access barriers and to rural clinic administration could benefit all rural residents.

Finally, Medi-Cal presents opportunities for change that could benefit farm workers and their families. Disconnection of MediCal eligibility determination from county welfare agencies, expanded outreach, and less frequent re-certification would all reduce access barriers for farm worker families.

to go back...we shouldn't have that debate in 1999. But we're still having it." (D.Ortiz)

"(F)armers in California seek to privatize profits and socialize costs." (S.Ali)

"(S)olutions have to come by tying farm workers and farmers together...(W)e cannot continue to support an industry without requiring that that support also includes support of farm workers." (S.Ali)

"In one...community I recently visited, I found three clinics within five blocks of one another - a migrant and seasonal agricultural workers' clinic, an Indian health clinic, and a rural health clinic - all struggling to survive, all with executive directors and administrative staff, and it just to me seemed crazy that...we could not approach from a community point of view the health needs of those populations." (P.Abbott)

9. POLICY RECOMMENDATIONS FOR IMPROVING FARM WORKER HEALTH AND ACCESS TO CARE

I. Refinement of Current State Policy:

1. Revise the Medi-Cal and the Healthy Families Programs to accommodate farm worker realities, including but not limited to:

(a) Provide children in Medi-Cal a full year of continuous coverage and eliminate quarterly reporting.

As California spends millions to enroll families in Healthy Families and Medi-Cal, thousands of eligible children including dependents of farmworkers are losing coverage because of quarterly status report requirements. Unlike children enrolled in Healthy Families or children who receive health insurance coverage through their parent's employer, families in Medi-Cal must file complicated reports with supporting documentation at least every three months, whether or not anything in their financial situation has changed. Temporary changes in family income and paperwork mistakes cause many children to cycle on and off Medi-Cal, disrupting the continuity of care that is so important to maintaining good health. This is not necessary - federal law allows California to provide children a year of eligibility with federal matching funds.

(b) Provide portable Medi-Cal coverage to eligible migrant farm worker families.

Federal law requires that all States ensure the definition of resident for State Medicaid eligibility purposes include "anyone who is living in a State with a job commitment or seeking employment in the State (whether or not employed.)" 45 CFR 233.40. The preamble to the rule notes that its key purpose is to assure that "migratory and itinerant workers receive Medicaid coverage." California's current Medi-Cal system, in effect, violates this rule by utilizing a county-based system. Each county determines eligibility for its residents and individuals must reapply when they move to another county. As a migrant follows the harvests through California, the Medi-Cal system forces this individual to reapply anytime this individual seeks health care access. County eligibility determinations vary in responsiveness and complexity. This in effect denies migrant farmworkers and their families access to the Medi-Cal program.

(c) Target Medi-Cal and Healthy Families outreach efforts to enroll eligible farm worker families.

(d) Broaden eligibility criteria consistent with allowable federal guidelines, including possible waiver requests.

Federal CHIP regulations allow California to receive enhanced federal financial participation for the creation of a Migrant and Seasonal Farmworker Health Service Initiative. (HIS) SB 672 (Escutia), currently in Senate Appropriations, would implement a Migrant/Seasonal Worker HSI. A HSI allows health care providers to address the farmworker community as a whole and not divide the community by Healthy Families eligible, Medi-Cal eligible, etc. Federal law allows the State to target the dependents of migrant and seasonal workers as a whole including

qualified and not-qualified immigrants, Healthy Families eligible and Medi-Cal eligible children.

(e) Reduce the length of application and streamline the application process for Medi-Cal and Healthy Families.

Implement Express Lane Eligibility that includes children in the Migrant Education Program. Farmworker parents of low-income children have already filled out forms for other programs with similar income requirements to Medi-Cal and Healthy Families. With parental consent, children already enrolled in programs such as School Lunch, WIC (Women, Infants and Children),Migrant Education, Head Start and Food Stamps should be easily enrolled in health insurance programs.

(f) Offer presumptive eligibility for children of farmworkers. The state can take up to 45 days to process a Medi-Cal application, forcing many children of farmworkers to wait for critical services. Presumptive eligibility for these would enable children who are likely to be eligible to receive care without delay.

(g) Revise share-of-cost requirements in Medi-Cal to take into account the seasonal nature of farm work.

Medi-Cal eligible persons over the Maintenance Need Level (MNL) have a share of cost in many cases that is primarily determined by income, typically verified through a check stub. Farmworkers experience tremendous fluctuation in monthly income due to the seasonal nature of farm work. During winter months, a farmworker family may be eligible for Medi-Cal without a share of cost and during peek harvest season, the farmworker family's income may exceed the MNL for no cost Medi-Cal. If the Medi-Cal program looked at this family's annual income, the family would most likely fall within Medi-Cal's no cost income limits.

(h) Establish pilot projects to test the feasibility of expanding eligibility and enhancing federal financial participation through the Medi-Cal program.

Section 1115 of the Social Security Act provides the Secretary of Health and Human Services with broad authority to authorize experimental, pilot, or demonstration project(s) which, in the judgement of the Secretary, are likely to assist in promoting the objectives of the Medicaid statute. Flexibility under section 1115 is sufficiently broad to allow states to test substantially new ideas of policy merit such as a unique insurance model for California's farmworker population. The authority provides flexibility, under the Secretary's discretion, for the provision of services which are not otherwise matchable, and allows for the expansion of eligibility for those who would otherwise not be eligible for the Medicaid program. The California Legislature should encourage the State to seek an 1115 waiver (or any other pilot available under federal law) with the intent of better serving the farmworker population.

2. Adapt education in the health professions to finance and reward training and practice suited to farm worker and rural conditions, including but not limited to:

(a) Promote access to medical schools for youth from farm worker families and rural communities who will return to practice in those communities.

(b) Urge the state's medical and nursing schools, particularly public institutions, to acknowledge the health needs of underserved Californians within their missions (financial support to meet the health care needs of farm workers and other rural indigents should follow this mission expansion). Explore the use of GME reimbursement dollars to provide such incentives.

(c) Expand the existing National Health Service State Loan Repayment Program and target placements to sites that serve farm workers.

(d) Encourage and provide incentives for greater involvement of universities and colleges located in the rural regions of the state in health issues associated with those regions.

3. Strengthen the Community Clinic System

According to 1990 figures, California's farmworker population consisted of 1,362,534 migrant, seasonal farmworkers and their dependents. Of this population, approximately 179,812 farmworkers and dependents sought care in migrant health centers in 1996. Migrant health centers are the providers of primary and preventive care to this population. As such these centers have developed culturally and linguistically competent personnel, sliding fee scale services, assistance with Medi-Cal eligibility and focused outreach and enabling services. The legislature must seek to strengthen this network to better serve the farmworker population.

(a) Increase the number of clinics in farmworker areas where services are largely or totally absent.

Due to the rapidly increasing number of uninsured, community clinics including migrant health centers need immediate capital and infrastructure expansion. Presently, clinics are at full capacity and must have infrastructure expansion in order to serve the growing uninsured population. Addressing the overwhelming health care needs of the uninsured with the current infrastructure will leave many of the uninsured without care. Without a commitment to expanding service delivery or creating new points of entry specifically for this medically vulnerable community, significant numbers of farmworkers will remain without access to primary and preventive care.

(b) Augment funding to farm worker clinics offering urgent care, week-end, and extended hours to farm workers.

By enacting State CHIP legislation that authorized the creation of Rural Demonstration Projects (RDPs), the Legislature recognized that California's rural population, in particular special groups such as seasonal and migrant workers, face unique barriers in accessing health care services. These barriers prevent farmworkers from having equal access to the health care services offered by the Healthy Families Program. RDPs are intended to mitigate some of the

barriers in order to ensure access to Healthy Families in rural California. California's Rural Demonstration Projects have assisted in providing migrant health centers with funding to ensure that clinics accommodate the work schedules of Healthy Families eligible farmworker dependents. The Legislature should continue their support of the RDPs.

(c) Target State Rural Health Services Small Grants and Rural Health Development Grants to reach more farm worker health care providers.

The Rural Health Services Small Grants Program (RHS Small Grant) makes awards to rural health care providers up to the amount of $25,000. The purpose of the RHS Small Grants is to help cover the operating costs of providing creative solutions to health problems in rural areas. The Rural Health Development Grants (RHDG) award up to $50,000 for capital expenditures that will enable eligible rural health care organizations to improve their health care infrastructure. Applicants must be located in a Rural MSSA. Funding for both programs comes from the Proposition 99 allocation. Although the needs of applicants exceed available funds, the funding level has steadily decreased due to the effectiveness of Proposition 99 in reducing smoking. The California Legislature must explore solutions to Proposition 99 funded programs, such as the RHS Small Grant and the RHDG programs, in order to ensure their continued viability.

4. **Assure that the California Department of Pesticide Enforcement enforces pesticide regulations.**

5. **Provide a rate enhancement for farm worker health services through programs such as Expanded Access for Primary Care (EAPC) to reward and encourage providers that:**

   (a) Provide bilingual services for monolingual farm workers.
   (b) Recruit, train and encourage the use of *promotores* (community health educators) to provide services for farm worker communities.
   (c) Connect traditional and family healers with conventional providers.

II. New State Policy Initiatives

1. **Create new funds through targeted taxes such as a tobacco, alcohol, or a "best food commodity tax" that would be targeted for farm worker health problems.**

2. **Target new state general fund base funding to farm worker health programs.**

3. **Create a campaign to raise awareness of the value and benefits of agricultural production to California including the contributions and hardships of farm workers.**

4. **Develop and fund health workforce "pipelines" (K-12 school systems, community colleges and baccalaureate granting colleges) to recruit and assist students who are likely to complete health professional training and practice in farm worker areas. Develop a statewide strategy to identify, develop, and support clinical sites for the training of health care professionals to provide services to the farm worker population. Develop statewide criteria for academic**

accreditation of rural training sites that offer experiences in farm worker health care to health professions students.

5. **Monitor farm worker health status and evaluate the impact and outcome of new and existing programs and services by conducting comprehensive assessments of the health outcomes for this population.**

6. **Create a health insurance program for farm workers which could include bi-national Coverage and accommodate services received by farm workers in Mexico.**

7. **Address the public health issues that cause farm workers to seek housing on Native American lands.**

8. **Expand pesticide poisoning education for providers serving farm workers.**

9. **Establish an interim Farm Worker Health Planning Task Force, to be convened by December 1999, with appropriate geographic, programmatic and financing expertise to develop a strategic plan to report on the findings of this Symposium.**

   (a) Present initial findings from the Symposium by the end of January and a final report and strategic plan in March to the Administration, Legislature and foundation funding community for use in the 2000-01 budget development and legislative process, as well as for grant making by California's major foundations.

III. Federal Health Policy

1. **Coordinate, streamline, integrate, and maximize the allocation of disparate funding sources for farm worker health services.**

2. **Ensure that the 2000 census accurately enumerates the farm worker population.** The Census *does not include migrant or seasonal farmworkers as a separate group. There is no category in the Census for "migrant" or "seasonal" farmworker. Moreover, the employment question is worded as "what did you do the week preceding April 1." Many migrant and seasonal farmworkers will not be doing farm work on this date. The difficulty in securing farmworker inclusion in the Census makes targeted efforts critical. Besides being the major source for planning, population assessment and political decisions; the Census is used to allocate an estimated $180 billion dollars from a variety of sources including publicly funded health care programs.*

3. **Revise Medicaid regulations to reduce barriers to the immigrant and farmworker populations.** *The United States has always experienced difficulties in securing participation of the migrant farmworker community in the Medicaid program. These difficulties are compounded by the lack of Medicaid reimbursement/coverage for migrant farmworker families that travel from their State of residency across State lines for work. In 1994, HCFA funded a feasibility study on interstate reciprocity conducted by Mathematica Policy Research, Inc.(MPR). Researchers at MPR proposed a five-year demonstration project based on an interstate enrollment transfer model in which States would recognize Medicaid eligibility determinations from other States for migrant families. MPR*

recommended that HCFA develop and make available to all States, a standardized application for migrant and seasonal farmworker families recognizing that the application process for Medicaid is cumbersome and differs across States. The application should adequately demonstrate agricultural employment and an income below the Federal Poverty Level. All other requirements for eligibility, such as residency and other income eligibility cutoffs, would not apply to migrant and seasonal farmworker families that have been verified. Once a migrant or seasonal farmworker family has been issued a Medicaid card, they are eligible for services across State lines. As mentioned previously, federal law requires California to ensure that the definition of residents for Medi-Cal eligibility purposes include migrant farmworker families. 45 CFR 233.40. These families have already been determined to be eligible in upstream States with similar eligibility requirements as California. Therefore, these families are eligible for Medi-Cal. A reciprocity program would merely eliminate the preclusive bureaucratic application process. The California Legislature should encourage California to enter into reciprocity agreements and encourage HCFA to fund the MPR five-year reciprocity demonstration project with California included as a participating state.

4. **Eliminate barriers to the use of the Worker's Compensation programs.**

5. **Increase unemployment insurance for farm workers.**

6. **Lobby Congress and the public broadcasting system for multi-lingual, multicultural programming on digital channels now under development.**

7. **Oppose temporary, foreign worker dispensations for the agricultural industry.**

8. **Change federal guidelines for the designation of rural areas to reflect mixed (urban/rural) counties in California and to maximize federal funding tied to these designations).**

IV. Public Health and Prevention

1. **Create new resources and supplement existing resources for the development of housing for unaccompanied male farm workers and for farm worker families.**

2. **Conduct a statewide assessment of the needs and resources in farm worker health to guide appropriate interventions, prioritization, and evaluation.**

3. **Maximize the use of public health personnel (public health nurses, community health educators, etc.) in farm worker communities.**

4. **Provide education and training to farm workers to prevent occupational injuries to the musculoskeletal system.**

California Program on Access to Care
Farm Worker Health Task Force

Ed Mendoza, Co-Chairperson
Office of Statewide Health Planning and Development
Sacramento, CA

David Lighthall, Ph.D., Co-Chairperson
California Institute for Rural Studies
Davis, CA

Andrew Alvarado, Ed.D.
College of Health and Human Services, CSU Fresno;
Latino Center for Medical Education
& Research; UCSF/Fresno

Bonnie Bade, Ph.D.
CSU San Marcos
San Marcos, CA

Elia Gallardo, Esq.
California Primary Care Association
Sacramento, CA

Mario Gutierrez, M.P.H.
The California Endowment
Woodland Hills, CA

David Hayes-Bautista, Ph.D.
Center for the Study of Latino Health
UCLA
Los Angeles, CA

Dolores Huerta
United Farm Workers
Keene, CA

Ventura Huerta
California Health Federation
Sacramento, CA

Claudia Martinez
UC Center, Fresno
Fresno, CA

Stephen A. McCurdy, M.D.
Agricultural Health and Safety Center
UC Davis
Davis, CA

John Miller
Health and Human Services Committee
California State Senate
Sacramento, CA

Gilbert Ojeda
California Program on Access to Care
Berkeley, CA

Anna Ramirez
California Department of Health
Sacramento, CA

Shoshana Zatz
Rural Community Assistance Corporation
West Sacramento, CA

NOTES

[1] All statistics in this section are from D. Villarejo, "Health Care among California's Hired Farmworkers," commissioned by California Project on Access to Care, 1999, pp.1,3,5,6.
[2] Medical Service Study Areas (MSSA) are designated by the Office of Statewide Health Planning and Development as small, geographic areas within which residents are likely to seek health care. Of the 487 MSSAs, 210 are "rural." "Rural" MSSAs are defined by the Rural Health Policy Council in the Department of Health Services as having a "population density of <250 persons per square mile and no incorporated community with >50,000 people." D. Villarejo, *ibid*, p. 2. 2000 census data may change some of these numbers.
[3] "Medically underserved" refers to a federal measure comprised of several weighted factors indicative of access to health services. A value less than 62.0 qualifies a MSSA for designation as "medically underserved."
[4] Villarejo, *op.cit.*, p.3.
[5] Latest available estimate from D. Lighthall, Symposium participant and Executive Director, California Institute of Rural Studies.
[6] Villarejo, *op.cit.*, p.6 and B. Bade, Symposium handout, p.1.
[7] B. Bade, *ibid.*
[8] D. Villarejo, *op.cit.*, p.6.
[9] K. Azevedo, presentation transcript, "Morning Session #2," Symposium on Expanding Health Care Access for California's Farmworkers, September 16-17, 1999. (Hereafter: Symposium.).
[10] *D. Villarejo, op.cit. p.10. This figure is based upon an in-depth case study of only one community.*

[11] Data in this section are from D. Villarejo, *op.cit.*, pp.8-11 and B. Bade, presentation transcript, "Morning Session #1," Symposium.
[12] "Back houses," located in the backyards of regular residences, are portrayed by local officials as temporary housing but are occupied year-round in over half the community surveyed. D. Villarejo, *op.cit.*, p.15.
[13] ERISA=Employee Retirement Income Security Act (1974). ERISA plans are not subject to mandates or regulation by states.
[14] This Corporation is designed to establish a model for attracting multiple community organizations and farm worker families to address health collectively, with better housing as a by-product.
[15] The process, designed to transcend traditional local divisions (class, race, public health-mainstream medicine) includes three phases: formation of a community health council, initial data assessment, implementation.
[16] K. Azevedo, *op.cit.*
[17] K.Grumbach, remarks in transcript, *ibid.*
[18] The "multi-factorial approach" to health, now formally termed "the multiple determinants of health," is an internationally successful, evidence-based framework for improving the health status of populations and individuals. Professor Emeritus Henrik Blum at the School of Public Health, UC Berkeley, introduced this framework to California in the 1960s. The latest, comprehensive text is R.Evans et al, eds. *Why Are Some People Healthy and Others Not? The Determinants of Health of Populations.* New York: Aldine de Gruyter. 1994.
[19] R. Rochín, presentation transcript, "Tape #4 Lunch Session", Symposium.