LYNDON B. JOHNSON
SCHOOL OF PUBLIC AFFAIRS

Working Paper No. 76

Migrant and Seasonal Farmworkers: Health Care Accessibility

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THE UNIVERSITY OF TEXAS AT AUSTIN

Working Paper Series
1994

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Migrant and Seasonal Farmworkers: Health Care Accessibility

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This research was conducted as part of a Policy Research Project on NAFTA and Health Care at the LBJ School of Public Affairs, directed by David Warner and Louis DeNino. The Policy Research Project received funding from the U.S.-Mexican Policy Studies Program, which in turn was funded by the Flora and William Hewlett Foundation, and from the Wilbur Cohen Professorship.

"A heterogeneous population of Black, White, Hispanic, Haitian and other ethnic backgrounds numbering between 2.7 and 5 million people, migrant and seasonal farmworkers endure substandard living conditions, labor in one of the most dangerous occupations in the nation, and have limited access to primary health care" ("Migrant and Seasonal Farmworker Health Objectives" 1990:2).

This assessment of the conditions faced by the migrant and seasonal farmworker population, although accurate, merely scratches at the surface of the many aspects of the lives of these people without probing the profound challenges faced by farmworkers in the United States and those who attempt to provide care for them. Only by looking at the varied aspects of the migrant and seasonal farmworker population--who they are, where they live, and what problems they have--can one gain a fuller understanding of the needs of this population. More importantly, it is only with this understanding that one can more adequately assess how the health and wellness demands of the migrant and seasonal farmworker population can be realized.

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Any inquiry to better understand the hardships endured by migrant farmworkers must first answer the difficult question regarding the composition of this population. Estimates of the number of migrant farmworkers in the United States generally range around three to four million, although there are estimates as low as 159,000 and as high as five million (Mountain 1993; Rust 1990). The difficulty in enumerating the migrant population is due in part to the differences in definitions and ambiguity in the terms used for migrant farmworkers by those conducting surveys and

releasing the results (Martin 1988:13). There is no standard definition for comparison across agencies ("Farmworker Health for the Year 2000" 1992:296). Further obstacles in determining the demographics of this population arise when one considers the large undocumented population, estimates of which vary from twenty to sixty percent of the total (Ryder 1993; Mountain 1993).[1] In general, what is known about the documented migrant farmworker population is that it is predominantly Hispanic, younger than average, largely a welfare population, and highly mobile (National Advisory Council on Migrant Health 1993:12).

The Special Agricultural Worker (SAW) and Replenishment Agricultural Worker (RAW) Programs enacted by the government in 1986 have also impacted the numbers and composition of the migrant farmworker population. The SAW legalization program was part of the Immigration Control and Reform Act (IRCA) of 1986 which granted temporary residence status to agricultural workers who had done at least 90 days of qualifying agricultural work in the twelve months ending May 1, 1986. Applications were accepted between June 1, 1987 and November 30, 1988; during this time 1.2 million workers applied for the benefits of this program. Of these, 350,000 were eligible to become "Group I SAWs," able to become permanent resident aliens after December 1, 1990 (Martin and Taylor 1988).

Because the workers who applied for and received temporary residence status or permanent resident alien status through the

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[1] Note: For the purposes of this paper, we will assume that all data refers to documented workers only, and will refer only to this portion of the population.

SAW program were not obligated to remain in agricultural work, it was expected that many would choose to leave agriculture as an occupation. In anticipation of a shortage of agricultural workers, the Replenishment Agricultural Worker program was enacted in 1989. The RAW program issued visas similar to the temporary residence cards given to SAWs. After three years of farm work, RAWs are eligible to apply for permanent resident alien or green card status; however, RAWs are deportable if they do not work in seasonal agricultural services for at least 90 days out of every year (Martin and Taylor 1988).

The migrational patterns and mobility of the migrant farmworker population has led to the division of the workers in the United States into three different areas, or streams (Figure 1). Each stream has its "homebase" downstream, in a winter crop area, where the farmworkers base themselves for the majority of the year. From the homebase states, the farmworkers migrate upstream to harvest the seasonal crops of the "non-homebase" states. Often the workers, the majority of whom are married and/or have children, will migrate north to the non-homebase states, while leaving their families in the homebase state for the season. The homebase states are Florida for the East coast stream, Texas for the Midwest stream, and California for the West coast stream. Due to the different migration influences as well as the differing crops, the demographics of the three U.S. streams have many differences.

Aside from the three streams in the United States, there are also a significant number of migrant farmworkers who are homebased in Mexico. Many of these farmworkers return home annually after the harvest season, while others decide to migrate more permanently into the U.S. The primary sending region in Mexico is the central plateau; about seventy percent of the migrants from Mexico to the U.S. come from the northern and western states of the central highlands (Mines and Massey 1985). The states of Zacatecas, Michoacán, Jalísco and San Luis Potosí are commonly cited as states from which many farmworkers migrate (Mines and Massey 1985; Stoddard 1984; Horton 1989). Homebases have also been identified in the Mexican states of Cuahuila, Chihuauhua, and in the communities of Ahuacatlan and Lacaja in the state of Guanajunato (Horton 1989; Hook 1993).

In the East coast stream, one finds a population that is primarily Puerto Rican, Haitian, and African American, with a strong and growing element of refugees from Latin America. In this group, the majority are single male workers, and therefore one will find a large number of solo-male camps along the East coast (Mountain 1993).

The Midwest stream has a population that is over 95% Hispanic, as many of the workers in this stream migrate directly into the stream from Mexico and South Texas. There is a larger prevalence of nuclear families in this stream, and one therefore will encounter fewer specific camps (Mountain 1993).

The West coast farmers historically drew their workers from imported laborers—Chinese in the 1880s, Japanese in the 1900s,

followed by southern European and Filipino into the 1930s—and then drew hordes of displaced Midwestern corn-belt farmworkers during the Depression (Goldfarb 1981:11). Currently, however, the demographics of the West coast stream indicate a sizable concentration of Hispanics, one larger than that of the East coast stream, but not quite as concentrated as the Midwest. Generally, there has been a strong nuclear family presence in this stream as well as a number of single males. Recently, however, there has been an influx of single women, especially from Central America, and hence one currently is seeing some solo female camps, as well as the previously present solo male camps (Mountain 1993).

Determining the demographics of the migrant population as a whole and in each of the streams is a difficult task; it is even more challenging to ascertain the differing health problems and subsequent health demands of these populations. The Migrant Health Program (Section 329, Part D, Title III of the 1962 Public Health Service Act) finances migrant and community health clinics across the nation with federal funding equivalent to approximately $100 per user per year, in order that they might provide the needed health care services to the migratory and seasonal farmworker population and their families (National Advisory Council on Migrant Health 1993:17). The efforts made by this program and others which attempt to serve the migrant population, to be discussed later in the paper, can only be considered as attempts, as they are not successful in reaching the population in large enough numbers.

The prevailing health problems that are seen in the migrant health clinics are those of a disease cycle similar to that of the Third World or of the United States in the 1930s. Infectious, parasitic and opportunistic diseases, such as tuberculosis, as well as other easily preventable health problems such as malnutrition are commonplace occurrences in the migrant health clinics (Mountain 1993). Up to 78 percent of the farmworker population suffers from parasitic infections at some time, compared with only two to three percent of the general population (National Migrant Resource Program, no date). A 1992 study in Florida found that 44 percent of the participants tested positive for tuberculosis (Centers for Disease Control 1992). The main reasons for the prevalence of these health problems are the housing and field conditions (i.e.: poor sanitation and facilities), both at the homebase and upstream, hunger, poverty, and the occupational hazards of agricultural work, such as exposure to pesticides and other dangerous substances and on-the-job injuries. Unfortunately, the occupational health and safety movement has been overwhelmingly oriented towards construction, manufacturing and mining, even though agriculture is one of the most dangerous occupations (Sakala 1987).

Health problems in this population are magnified and perpetuated by the difficulty of disease management due to the high mobility of migrant patients and lack of a viable data transfer system between clinics in different communities or states, as well as by the fact that the social services for the migrant farmworker population are poorly funded and inadequate

(Mountain 1993). Federal funding under the Migrant Health Program is granted to 105 migrant health centers nationwide. These funds are then distributed to approximately 400 clinic sites nationwide (Figure 2), at which there are an estimated 500,000 encounters per year (Wilk 1986:13; Rust 1990). This accounts for approximately 13% of the migrant farmworker population. Most clinics that receive migrant health monies also receive funding through other federal programs, and therefore provide services to other low-income families as well (National Association of Community Health Centers 1991:6). Except for Puerto Rico there are no clinic sites in the U.S. that solely serve migrants (Braña 1993).

A further concern is the low educational level of the farmworker population. The average educational level of migrant farmworkers was 6.4 years in a study conducted in 1986 (Littlefield and Stout 1988). Without an adequate education, the concept of health promotion and disease prevention is difficult to comprehend. This can have serious consequences when confronting a disease process such as AIDS. A 1988 study conducted in rural Georgia by David Foulk found that migrant farmworkers have lower levels of education about AIDS than the general population, leading to numerous false assumptions about the transmission of the disease and the disease itself. The need for the prevention of AIDS was not understood by 38.8% of the participants, who did not realize that AIDS is a fatal disease (Foulk 1989).

Just as the demographics and the agricultural influences change through the three streams, so do the prevalent health care problems. Furthermore, the health problems differ within each

stream between the homebase and non-homebase states. However, due to time and travel constraints, the attention of the remainder of this paper will be directed at Texas and the Midwest stream. The focus will be on the health status and access to health care of the population; a summary of the general health conditions of this population will be followed by an overview of the available programs for migrant and seasonal farmworkers. Presentation and discussion of the results from the Health Care Accessibility Survey conducted in Webb and Cameron counties for this project and delineation of areas for further research will conclude the paper.

General Health Conditions in the Midwest Stream

In 1986 and 1987, the Migrant Clinicians Network (MCN), with technical support from the National Migrant Resource Program and funding from the U.S. Department of Health and Human Services, Bureau of Health Care and Delivery Assistance, and the Migrant Health Program, examined data from four Midwest stream migrant health centers in Texas, Michigan and Illinois, as well as from community health centers for two control group counties. The purpose of the study was to test the hypothesis "that Hispanic migrant and seasonal farmworker populations differ from the Hispanic population *per se*." The findings of the study revealed that migrant farmworkers have age-specific health problems that are different and more complex than those of the general population. The farmworkers had more clinic visits than the general population for some health problems, including a higher-than-normal occurrence of infectious disease, diabetes, pregnancy,

hypertension, and contact dermatitis and eczema. Their visits to the clinic for general medical exams, however, was 39 percent below the national average.

In general the findings provide solid evidence that the health status of the farmworker population is "far below that of the general population," as well as being different from other populations in terms of the problems it encompasses. Also revealed through this study was that the overall health of the homebase farmworkers, at least in the clinics studied, was significantly worse than that of the general United States population or farmworkers in non-homebase areas (Dever 1991). Due to the fact that the homebase states generally have a highly concentrated migrant and seasonal farmworker population, there is more competition for the available health services, leading to the disparity in the health status of the homebase versus non-homebase communities.

The high prevalence of infectious diseases in the farmworker population studied by the [Migrant Clinicians Network] is a serious issue because these diseases persist and progress amid the poor living conditions of the farmworker population. Among the concerns associated with substandard living conditions is water quality. In the summer of 1987, a community and migrant health center in Pullman, Michigan (Pullman Health Systems) conducted an assessment of the water quality of the wells serving the migrant and farmworker population. The results of these tests indicated that "some wells" were potential health hazards with either short or long term usage due to high levels of bacteria. The

contaminant range in these wells was from 0 to 84 MF coliform count/100ml, while the safety limit for bacteria is zero MF coliform count/100ml. This led the board of directors of the center to support a plan to test the wells annually in an effort to determine whether the nitrate concentration increased from year to year. Future efforts of this center will focus on previous screening and education projects as well as the institutionalization of groundwater educational services (Miller 1990).

Among the many problems suffered by both homebase and non-homebase migrant farmworkers in the MCN study, diabetes mellitus was the most common problem in the migrant health centers, accounting for 8.3 percent of the total diagnoses in the clinic during the study period (see Table 1) (Dever 1991). The high incidence of Gestational Diabetes Mellitus (GDM) was recognized by the certified nurse-midwives at the maternity center of the Brownsville Community Health Center in Texas, and this led to the development of a program of maternity care for gestational diabetes. This program tested the clients for GDM, and then provided nutritional training and frequent testing for those diagnosed with GDM (O'Brien 1988). The need for programs such as this one has been recognized in the Midwest Migrant Health Information Office (MMHIO). The Camp Health Aide Program was formulated by the MMHIO as an educational program designed to bridge the gap between the existing health care system and the health care needs of the migrant farmworkers. Migrant women (and a few men) are trained by MMHIO staff members to act as health

resources in the migrant camps. This program, which began with a pilot program in Michigan in 1985, and has since expanded to eight sites in four Midwestern states, benefits farmworkers, health centers, outreach programs and workers, as well as the participants themselves (Robinson 1990). Although this program has been successful, a greater number of programs which facilitate the utilization of health services by the migrant farmworker population are needed.

Available Programs for Migrant and Seasonal Farmworkers

There are a paucity of health programs designated specifically for migrant and seasonal farmworkers. The federally funded Migrant Health Program and the Gateway Community Health Center, Inc. Entitlement Program are two such programs. Medicaid covers those farmworkers who meet its eligibility requirements in each state, and there is currently a study being conducted to determine if an interstate reciprocity program would be feasible (Wright 1993). In Texas, the Community Oriented Primary Care Association, Inc. (COPRIMA), although not exclusively for migrant and seasonal farmworkers, does provide services to eligible farmworkers (Gonzalez 1994).

Migrant Health Program

The Migrant Health Program (MHP) is a branch of the Division of Primary Care Services in the Department of Health and Human Services. A federally funded program created under sections 329 and 330 of the Public Health Service Act of 1964, the MHP served only migrant farmworkers from 1964 through 1970, when it was

expanded to include services for seasonal farmworkers (Wright 1993). The program is administered by the Health Resources and Services Administration (HRSA) and its budget for FY94 was $59 million, a 2.9% increase from FY93 (Kavenaugh 1994). Grants are distributed to health centers by the total number of migrant and seasonal farmworkers in their service area, with highest priority given to centers with over 6000 migrant farmworkers and lowest priority given to those sites serving less than 6000 seasonal agricultural laborers. Approximately 105 organizations, mostly non-profit, receive direct funding and then many distribute these funds to satellites or other centers (Kavenaugh 1994). Program eligibility is based on the family's preceding two years of employment in agriculture and income history.[2]

Gateway Entitlement Program

As of 1986, there were only a few farmworker hospitalization insurance plans nationwide, including Mutual of Omaha, Florida Agricultural Health Plan of Blue Cross/Blue Shield in Jacksonville and the Gateway Community Health Center, Inc. Entitlement Program in Laredo. Of these, the Gateway Entitlement Program is the only one that continues to exist. It is a program funded by the United States Department of Health and Human Services in conjunction with Blue Cross/Blue Shield of Texas, Inc., which provides health benefits for enrolled migrant farmworkers. The total budget of the program is $345,000, which covers participants from Laredo for care in 49 counties in the Texas panhandle and the rest of the

[2] For full cite and client eligibility information, refer to Part D, Subpart I of Section 329 of the Public Health Service Act.

United States for hospitalization and non-preventive care (Treviño 1994).

Any farmworker homebased in Webb County who does not have insurance coverage and can pay the registration fee (approximately $7.00/person) and monthly premium ($13.69/month/person) is eligible for coverage under this plan. Four hundred and seventeen families were covered in 1992-1993, with a goal for the 1993-1994 year of 2100 enrollees.

So far no admission of legal status in terms of eligibility to insurance plans.

Proposed Medicaid Reciprocity Program

Although Medicaid is designed to aid families and individuals living in poverty, which a large majority of migrant and seasonal farmworkers do, the structure of the Medicaid system is more hindering than helping. Requirements of state residency and specific documentation, combined with slow application processing, present barriers to eligible farmworkers. Because Medicaid eligibility requirements are determined by each state, a farmworker family may be eligible in one state, yet ineligible in another. In Texas, for instance, pregnant women and infants at 185% of the federal poverty level are eligible for Medicaid, whereas in Ohio Medicaid cuts off at 133% of the federal poverty level ("Medicaid Source Book" 1993:185)

In order to improve the Medicaid participation of migrant and seasonal farmworkers, the Health Care Financing Administration (HCFA), in cooperation with the Office of Migrant Health of the Bureau of Primary Health Care of the Health Resources and Services Administration is supporting a feasibility study for a HCFA-sponsored demonstration. A number of proposals on how to increase

migrant participation have been suggested. Congress has expressed an interest in federalizing the Medicaid process by establishing a national set of services and a single eligibility standard. The proposal being studied by HCFA is one that includes interstate agreements through which two or more states agree to honor one another's Medicaid eligibility for migrant farmworkers. Although the eligibility and coverage differences between states will likely cause some problems, the outlook for the demonstration is promising (Wright 1993).

COPRIMA

COPRIMA is a Texas Department of Health-funded program which provides primary care coverage to eligible clients through contracts with local providers at thirty-four project sites in seventy-six Texas counties. Funding comes from the Community Oriented Primary Care Division of TDH. The total budget for the Brownsville site for FY94 was $345,712, with 15 percent coming from the federal Title V program (Gonzalez 1994). In order to be eligible, one may not have any other type of insurance and must be employed. Proof of income, no more than 150% of the poverty level, state residency, photo identification, and the payment of a registration fee ($5.00/person below 100% poverty and $7.50/person above 100% poverty) are required for enrollment. Enrollees are covered for the period of one year, unless there is a change in their eligibility. Coverage includes up to $100 each for emergency care and lab work or x-rays, and $40 per month in medications, as well as providing health education classes in the *colonias*. The COPRIMA program in the city of Brownsville services

the four local colonias and currently serves around 825 clients, with a goal of 1000 (Gonzalez 1994).

Health Care Accessibility Survey Results

Purpose

The purpose of the research was to investigate health care and health care accessibility problems faced by migrant and seasonal farmworkers. Due to the fact that less than fifteen percent of this population is being seen in the federally funded clinics and programs (National Association of Community Health Centers 1991), we were interested to find out whether the remainder were obtaining services in other United States facilities, in Mexico, or not at all. The sites of Brownsville and Laredo were chosen because south Texas serves as the homebase for a significant number of migrant and seasonal farmworkers. A study of the farmworker population in Texas for 1987 estimated their numbers at 513,731 statewide. The 1987 estimates for the Lower Rio Grande Valley (including Cameron, Hidalgo and Willacy Counties) and the Laredo area (Webb County) are 265,807 and 12,568, respectively; these estimates combined represent 54.7% of the total estimated farmworker population in Texas (Plascencia 1989:74-79) The proximity of these two cities to Mexico was of further importance. The timing of the study in the late winter and early spring was due to the fact that at that time most workers have returned from their upstream work sites.

The *colonias* visited for the interviews, Rio Bravo in Laredo and Cameron Park and Olmito in Brownsville, house the majority of

migrant and seasonal farmworkers in these two cities. Rio Bravo is an incorporated city located approximately 10 miles from Laredo and has a population of approximately seven thousand. Cameron Park is about three miles from Brownsville and has a population of four to five thousand inhabitants. Olmito is an incorporated city located approximately five miles north of Brownsville with fifteen hundred to two thousand inhabitants (Gonzalez 1994; Peña 1993). The infrastructure in these *colonias* is poor. Inadequate street drainage and garbage collection has led to appalling and dangerous living conditions.

Methodology

The data collection tool used for the research was a survey, with approximately forty questions concerning demographics, housing conditions, migration patterns, health problems and health care service utilization (see Appendix). The survey was administered verbally to representatives of forty-seven migrant farmworker families, both in Spanish and English, in the homes of the farmworkers and at clinic sites.

In Laredo, we contacted the Gateway Community Health Center, where Gloria Peña, Director of Patient Services, set up interviews with several migrant families at the clinic. In Brownsville, Tony Zavaleta, Ph.D., Dean of the College of Liberal Arts at the University of Texas at Brownsville, and Director of the Community Oriented Primary Care Association, Inc. (COPRIMA) referred us to the administrative assistant of COPRIMA, Alice Gonzalez. A community worker with COPRIMA accompanied us during the interviews in the Cameron Park *colonia* outside of Brownsville.

Results

Demographics. Nearly all of the migrant farmworkers interviewed were married (96%) and had children (89%). Seventy-seven percent of those responding to the survey were female. The average age of all respondents was 36.8, with ages ranging from 19 to 64. The average family had 3.5 children still living at home. The average age of the children living at home was 11.3 years, with ages ranging from 3 months to 32 years. Although seventy-four percent of the participants were born in Mexico, most stated that they were legal residents and nearly all (98%) had resided in the United States for more than five years.

Housing Conditions. Eighty-five percent of those surveyed owned their own homes, although most were still making payments on the property, thirteen percent rented and two percent (representing one family) had been unable to locate housing at the time of the interview. Basic housing necessities, such as running water and indoor plumbing, were lacking in a significant number of the houses of the farmworkers interviewed. Thirteen percent did not have running water and twenty-one percent were without indoor plumbing (Figure 3). It is important to note that several of the participants were living in trailers and other recreational vehicles which had hookups; otherwise it is not likely that most of these people would have had access to indoor plumbing and/or running water. There were an average number of six people living in homes with an average of two bedrooms (Figure 4).

Migration patterns. All participants maintained their homebases in Laredo and Brownsville, where most (87%) had lived

for over three years. They migrated to numerous states for work. Twenty-two states were mentioned with the most common being California, Florida, Michigan, Minnesota, and Ohio. Eighty-three percent had migrated annually for more than three years, while only a small percentage (6%) had entered the migrant stream in the past year. The importance of family unity during the migration was shown by the number of workers who traveled and worked with their spouse, children, and/or other extended family members (Figure 5). Eighty-one percent traveled with their spouses, eighty-one percent with their children, and forty-nine percent with extended family members, while only six percent traveled alone. Most of the families lived and worked outside of Texas for a period of three to six months annually (Figure 6). For many families this migration occurred during the summer months when the children were not in school and were able to work, indicating a strong education ethic and that the financial contributions of the children were vital to the families' survival.

Health problems and health care service utilization. Most respondents thought that one should seek medical attention under various circumstances, including routine check-ups, acute illnesses, chronic illnesses and muscular pain or discomfort. However, the majority actually sought medical attention only when there was an acute illness (Figure 7). When asked what medical problems they had experienced in the past two years, eighty-one percent identified acute illnesses, such as ear infections and colds, while only thirty-six percent had seen a health care provider for routine checkups. Considering the number of women

interviewed, this indicates low participation in annual gynecological exams.

Although some families indicated that they were able to get insurance through their employment outside of Texas, sixty-seven percent of the adults and forty-five percent of the children were uninsured at the time of the interviews. The largest insurer of children was Medicaid, at forty-nine percent, while four percent were covered through other agencies, including COPRIMA and the Gateway Entitlement Program (Figure 8).

Medical attention was sought in both the United States and Mexico. Fifty-seven percent of those interviewed utilized health care services exclusively in the United States, while thirty-two percent used binational services, and eleven percent sought care only in Mexico (Figure 9). It is important to note that the United States utilization includes both Texas and non-homebase states, where, as some respondents indicated, it is easier to access health care due to the less stringent Medicaid eligibility requirements, and the care is perceived to be better.

In the preceding two year period, forty percent of the participants had visited a health provider ten or more times, however a significant portion of these visits were for pediatric care. Approximately half of those interviewed sought medical attention from private physicians and clinics, while only six percent went to the hospitals for their medical needs (Figure 10). The almost exclusive use of private physicians by those who seek care in Mexico and by children insured through Medicaid, accounts

for the seemingly large number of migrant farmworker families who visit these health care providers.

The majority of the children born to the respondents were born in the United States. In both Mexico and the United States, the most common attendant at birth was a midwife. Fifty percent of the total births were delivered by midwives, while thirty-six percent were in hospitals and fourteen percent in clinics (Figure 11). As was perceived and recalled by the respondents, the average cost for delivery was approximately $200 and $380 in Mexico and the United States, respectively.[3]

General Impressions. The population we surveyed was afflicted with many of the health and social problems that we had encountered in the literature. Inaccessibility to health care services, lack of transportation, emphasis on curative as opposed to preventive care were common characteristics among the participants. Problems generally associated with low income families were exaggerated when less common medical problems arose, as was the case with some of the participants.

Many of the farmworkers interviewed expressed concerns not only about their own health, but about the health of others that they knew. One woman interviewed had a sister with an auto-immune skin disorder which required constant medical attention, but she was unable to receive care because she was uninsured and ineligible for Medicaid. Other participants indicated that the cost of medical services has inhibited them from seeking care.

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3 This does not include the cost of delivery and care of one child born prematurely, with a cerebral hemorrhage. The cost of this care was US$415,000.

The shortage of doctors brings about a further concern that diseases will become too advanced before care can be sought.

A number of the participants stated that they were disappointed with the medical system in the United States. One reason for this is the farmworkers' perception that in the U.S., the health care providers are more concerned with the insurance status of the patient than with the potential health problems. In Mexico, on the other hand, this concern is perceived to be the reverse, as the Mexican providers are interested in addressing the patients' health problems before the patients' ability to pay.

We interviewed families who have children with disabilities, such as Down's syndrome, spina bifida, and a neurological disorder. The child with Down's was one of eleven children living with their parents in a mobile home with no hot water. Despite the fact that half of the children were United States citizens (including the child with Down's), the mother stated that they had been chased away from clinics where they were accused of "just wanting to use U.S. social services."

The child afflicted with spina bifida lived in a one bedroom recreational trailer where six people were living. The parents slept in the back bedroom, while the four children shared a bed in the front area of the trailer. At the time of the interview, the child was bathing in a tin washtub; the mother of the child stated that this was how she kept the child cool, since there was no air conditioning and the ventilation in the trailer was poor.

Other comments concerned the feeling of alienation experienced by the farmworkers. The community health centers in

Laredo and Brownsville are currently unable to accept new clients due to health provider shortages. Because these clinics receive Migrant Health Program funding, the farmworkers feel that the clinics should be able to accommodate them, just as the clinics upstream do. The alienation felt is not only from the health care system in particular, but from the area's population in general. The residents of Rio Bravo, located about 10 miles from Laredo, feel animosity from their neighbors in Laredo. For example, they have to travel to Highway 83 in order to receive emergency services because the ambulances will not enter the *colonia*.

Discussion

There were several limitations to this study. The sample size is small and therefore the results cannot be assumed for the entire population of migrant and seasonal farmworkers. There were some complications in the administration of interviews due to the lack of a direct translation from English to Spanish of some of the questions in the survey. The randomness of the sample was affected by the fact that some potential respondents were unwilling to talk to us without a community member present. The presence of the community member, although it allowed us to conduct the surveys, may have affected the way in which the participants responded.

Despite the limitations of the study, the impoverished conditions mentioned in much of the literature were evident in the population we surveyed (Wilk 1986:13). Interviews in Cameron Park were conducted during winter weather conditions, and aside from

the need for general housing necessities previously mentioned, the lack of heat and proper insulation and the inferior housing materials, including many homes with cracks in the walls, required that the inhabitants of the homes wear multiple layers of clothing to endure the cold. The unpaved roads and poor street drainage made it nearly impossible for residents to drive or walk when it rained.

A single mother with ten children residing outside of the Brownsville city limits lived in two dilapidated recreational trailers. The trailers had no plumbing hookup, and the family collected rainwater in outdoor barrels for the purposes of drinking, cooking, and bathing. Much of the floor area was dirt-covered with decaying food and animal feces also strewn about. Social services had been unsuccessful in locating public housing for the family because of the occupancy limits per unit. When we went to interview the family, the children were unattended while the mother was in Mexico and they had been relying on food found in the dumpsters of restaurants for their meals.

The general consensus of the participants was one of dissatisfaction with health care accessibility and services in the United States, especially in the homebase area. Complaints of the farmworkers interviewed included long lines to see providers, unavailability of immediate appointments, impersonal attention, and high cost of services due to lack of insurance and stringent Medicaid requirements. As a result of these problems, and as is consistent with the current literature, this population most commonly seeks curative rather than preventive health care

services. Most migrant farmworkers interviewed also indicated that there were changes that could be made to the current health care system, including the ability to pay for services through some sort of payment plan, and a national health care program.

Areas for Further Research

The lack of research on migrant and seasonal farmworkers has combined with a lack of public policy which pertains to this population and a deficiency in other efforts that would prove advantageous to this population. One of the primary reasons for this deficiency is the problem of research and the methodology associated with that research. Much of the research done on migrant farmworkers is extremely out of date, having been done in the 1960s and 1970s (Arnold 1988:2). More recently, census figures have been used in attempts at enumerating the farmworker population. The census data, however, is considered unreliable for this purpose because it is collected in April and categorizes employment according to the job held most recently in the previous two weeks. Often, a migrant farmworker will not yet be performing agricultural work in April, as the harvest seasons for many products have not yet arrived. Also, problems may arise from this population being undercounted in general and from the population homebased in Mexico which is missed entirely. Therefore, it is probable that a large portion of the migrant population is classified in some other employment or as unemployed. Differences in definitions of what constitutes a migrant farmworker, as well as the inclusion or exclusion of dependents are other potential

difficulties in the attempts to count the farmworker population ("Farmworker Health for the Year 2000" 1992:295-296).

The problems faced in enumerating the farmworker population accurately complicates the research of the health status of farmworkers. Some regional studies have been completed, and while these studies may be somewhat useful at the local, state, and possibly even stream levels, the applicability of these studies to the farmworker population as a whole is limited. Problems arise when, as often happens, these studies are used to represent the farmworker population at large. Often, when similar studies are conducted by separate agencies in different migrant streams, there are conflicting results produced. The insufficient data on the population and on the study methodology itself makes it difficult to determine what variables are producing the contradictory results. This is not to say, however, that it is impossible to obtain reliable health data for the farmworker population—only that a population-wide effort has not yet been made (Galarneau 1992).

In order for the health status of the migrant and seasonal farmworker population to shift toward that of the general population, attention must be paid to these deficiencies and changes must be made. These changes must be executed at all levels--from an increase in preventive services, health education and outreach at the local migrant and community health center level, to the formulation of case management services and a viable data transfer system among the clinics in each stream and

nationwide, all the way to the recognition of these problems in the nation's capital as legislation is formulated.

Because the migrant and seasonal farmworker population is so different from that of the United States in general, there is a need for a health care delivery system tailored to this population. This health care must be specific to their needs both as migrants and as a distinct culture (National Advisory Council on Migrant Health 1993:18). Preventive care, such as prenatal care for pregnant women is a vital part of a health delivery system. Many of the migrant farmworker women fall into high-risk groups, have unplanned pregnancies, and are unable to afford care. The lack of prenatal care in the migrant farmworker population has led to an increased incidence of infant mortality, miscarriage, and pregnancy complications (National Advisory Council on Migrant Health 1993:37). Education of the farmworker population is another way of preventing some of the more basic health problems that they suffer. By training farmworkers in such essential concepts as nutrition, basic child care, recognition of symptoms of serious health difficulties, and the importance of timely attention to health problems, they will be better able to care for themselves and their families, and they will be more inclined to seek health care when they need it.

As previously mentioned, the farmworker population has a high need for medical attention, but the current funding in the migrant and community health centers is ineffective. The isolation of the workers and their frequent inability to reach the clinics have been cited as reasons for the extent to which health care is

unavailable to farmworkers. Community outreach programs, using both clinical and lay health advisors have proven effective in providing needed health care services to migrants. An increase in the number of these outreach programs, especially in the rural areas where federal clinics are nonexistent, will lead to improved health care for migrant and seasonal farmworkers nationwide (National Advisory Council on Migrant Health 1993:53).

An additional obstacle in adequately serving migrant and seasonal farmworkers is the inability to track individual workers and their health status. An information system would help diminish problems such as loss of medical records by the farmworkers and the inability to track the immunization status of children. Such a system would also be a necessary precedent to the much needed viable data transfer system between clinics in a stream and nationwide (Mountain 1993). An electronic system that would allow the transfer of data from an upstream clinic to the patient's homebase clinic, providing the downstream clinic with information on the status of the patient and his/her treatment, would greatly decrease the duplication of treatments by different clinics. Because such a system will require both time and resources to develop, it is necessary to emphasize to farmworkers the importance of hand-carrying their medical records to the various health providers they seek in the stream.

Other efforts should be directed towards the creation of an international insurance program for migrant farmworkers, such as the insurance plan developed by the Western Growers Association to provide health care in Mexico for farmworkers who work in the

United States ("Health Care Across the Border" 1993:12-13). As our research indicates, a significant portion of the population is utilizing services in both the United States and Mexico.

Although the migrant and seasonal farmworker population is largely a minority population, traditional minority solutions are inadequate to treat their problems. The unique aspects of the migrant farmworker lifestyle require innovative and multicultural solutions. As one migrant farmworker stated, "Clinton said he would address health care; instead he has addressed wars in other countries. Meanwhile, we are fighting wars in our own country. The war against poverty, the war against poor health, the war against gangs, and the war against malnutrition. We are losing these wars."

Table 1: Ten Most Common Diagnoses in Migrant Health Clinics[1], Number and Percent, All Ages, 1986-1987

Rank	Diagnosis	Total Number	Percent
1	Diabetes Mellitus	580	8.3
2	Health Supervision of Infant or Child	472	6.7
3	Otitis Media	414	5.9
4	Normal Pregnancy	396	5.6
5	Acute Upper Respiratory Infection	315	4.5
6	Essential Hypertension	298	4.2
7	Consultation without Complaint or Sickness	195	2.8
8	Hard Tissues of Teeth Disease	184	2.6
9	Contact Dermatitis or Other Eczema	157	2.2
10	Common Cold	147	2.1

[1] These numbers are based on a study of 6,969 total patients in a study conducted in four migrant health clinics: Migrant and Rural Community Health Association (Michigan), Indiana Health centers (Indiana), Hidalgo County Health Care Corporation (Texas), and Su Clínica Familiar (Texas).

Source: Dever 1991.

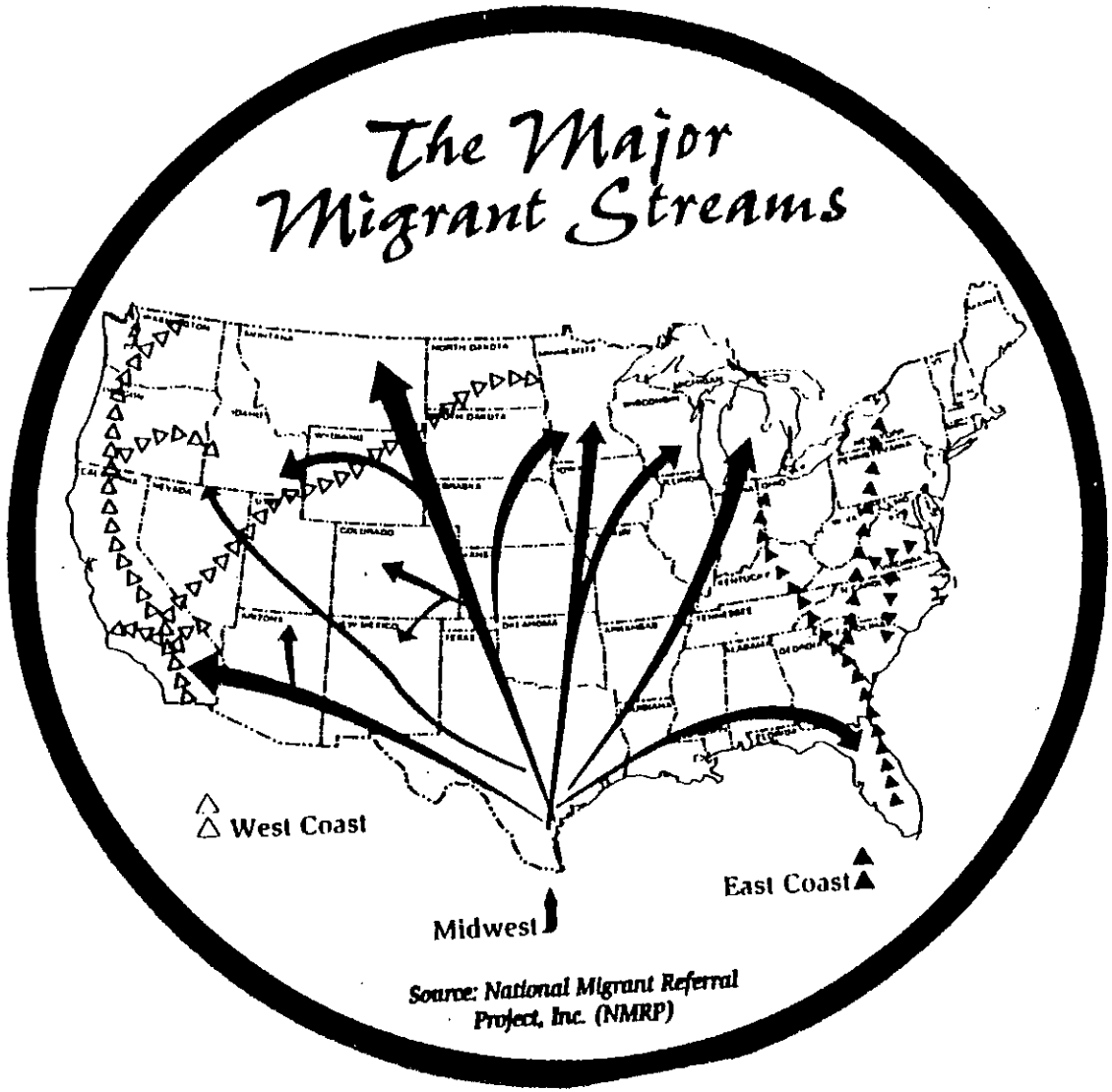
The Major Migrant Streams
West Coast
Midwest
East Coast
Source: National Migrant Referral Project, Inc. (NMRP)

Figure 1

Migrant Health Centers Funded Through PHS Section 329

Migrant Health Pr
Rockville, MI

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National Migrant Resource Program, Inc.
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May 1992

Figure 2

Figure 3: General Housing Necessities (n=46)

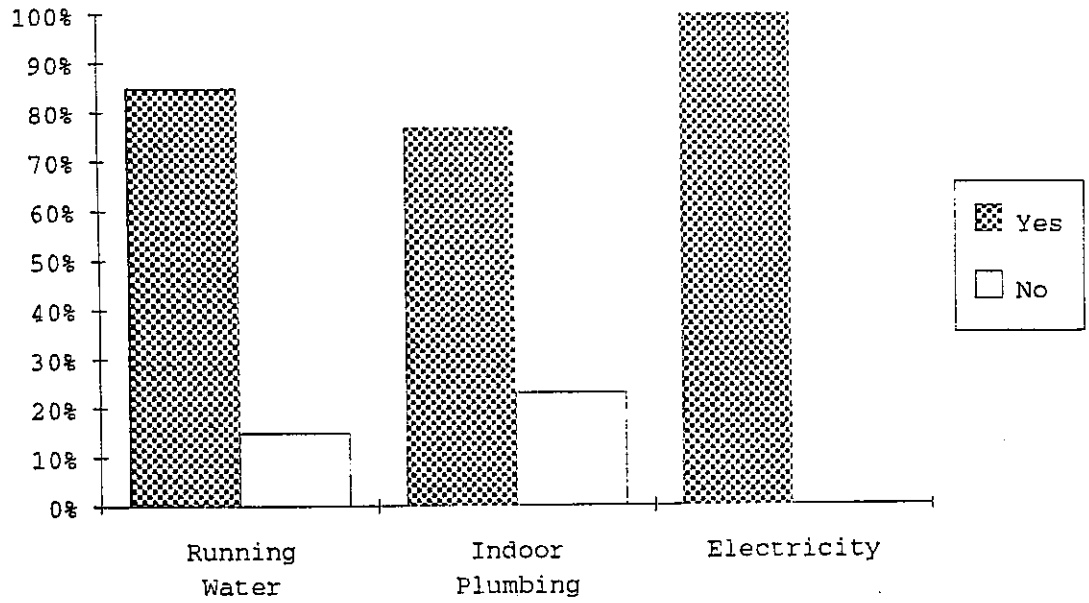
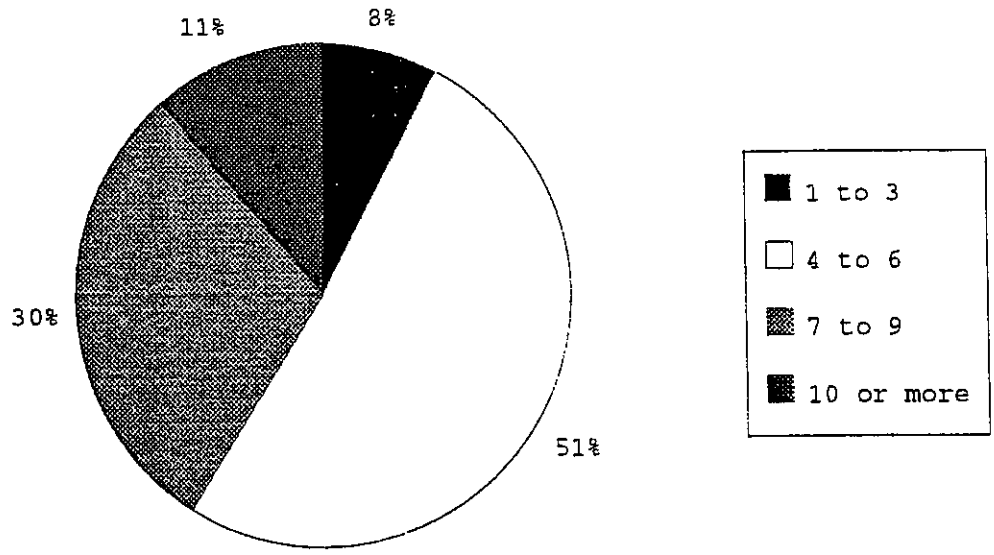


Figure 4: Number of Occupants per Household (n=47)



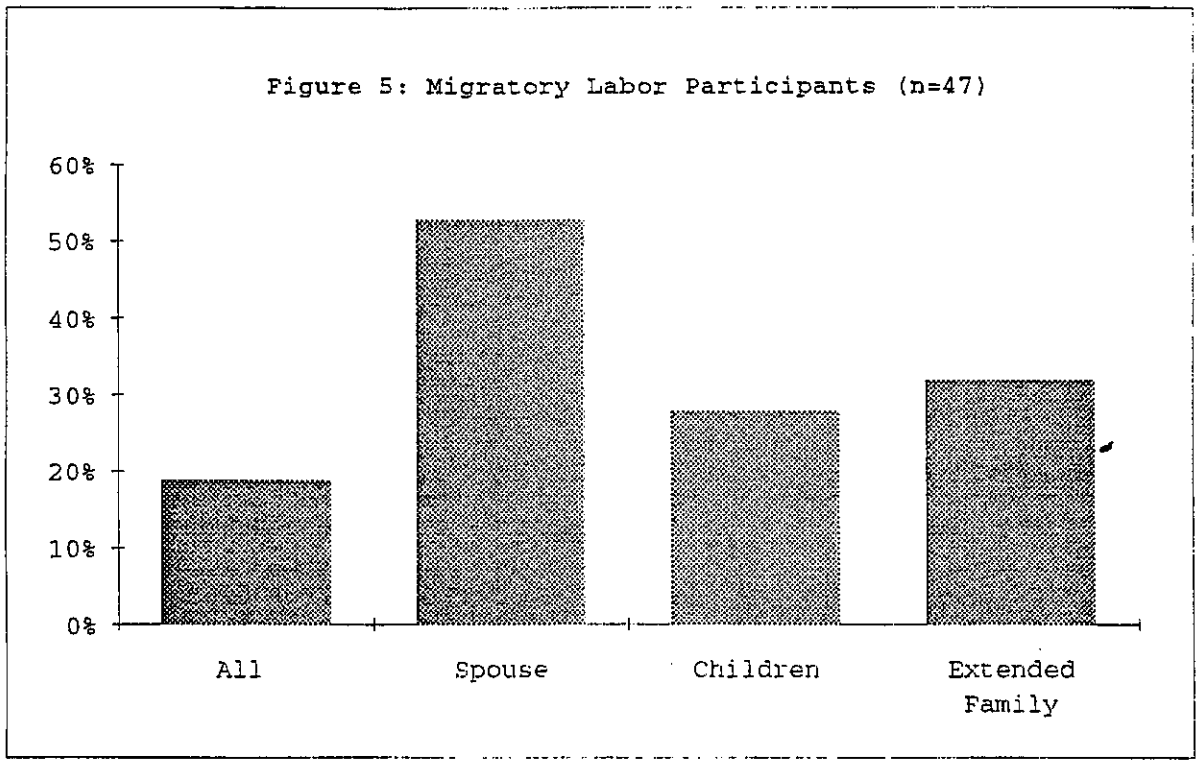


Figure 5: Migratory Labor Participants (n=47)
60%
50%
40%
30%
20%
10%
0%
All
Spouse
Children
Extended Family

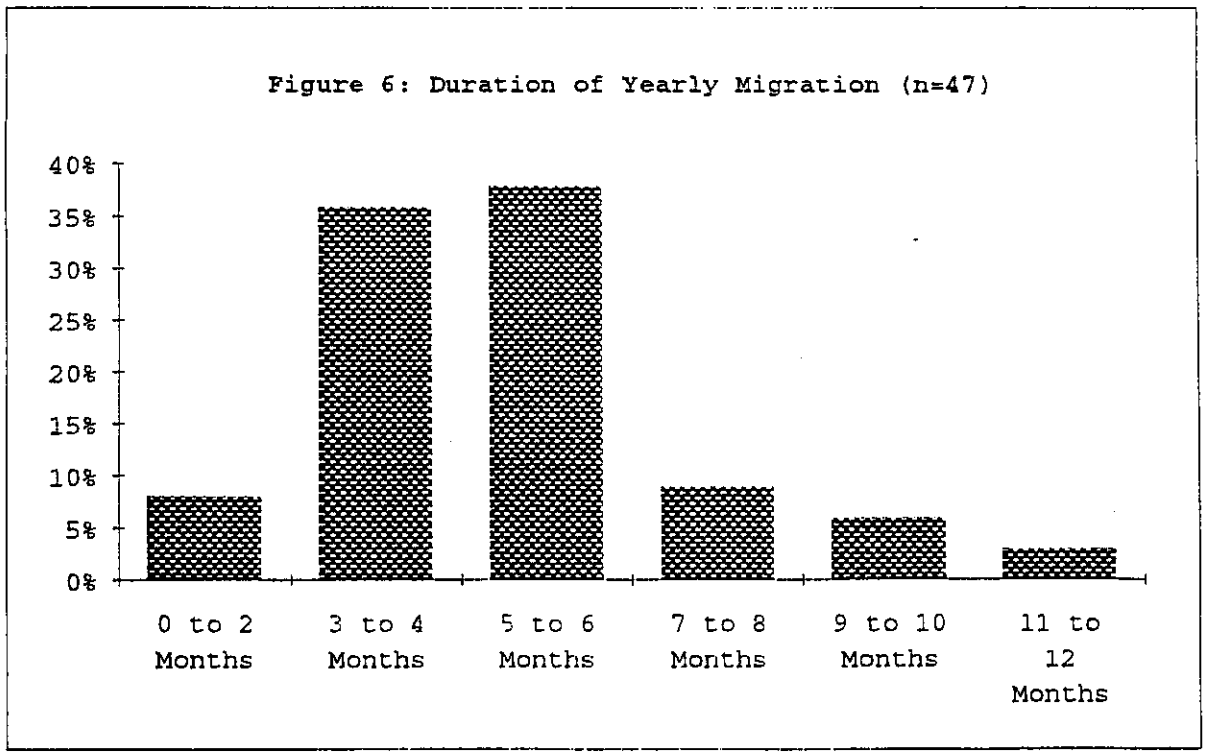


Figure 6: Duration of Yearly Migration (n=47)
40%
35%
30%
25%
20%
15%
10%
5%
0%
0 to 2 Months
3 to 4 Months
5 to 6 Months
7 to 8 Months
9 to 10 Months
11 to 12 Months

Figure 7: Medical Attention: Desired Versus Actual
(n=47)

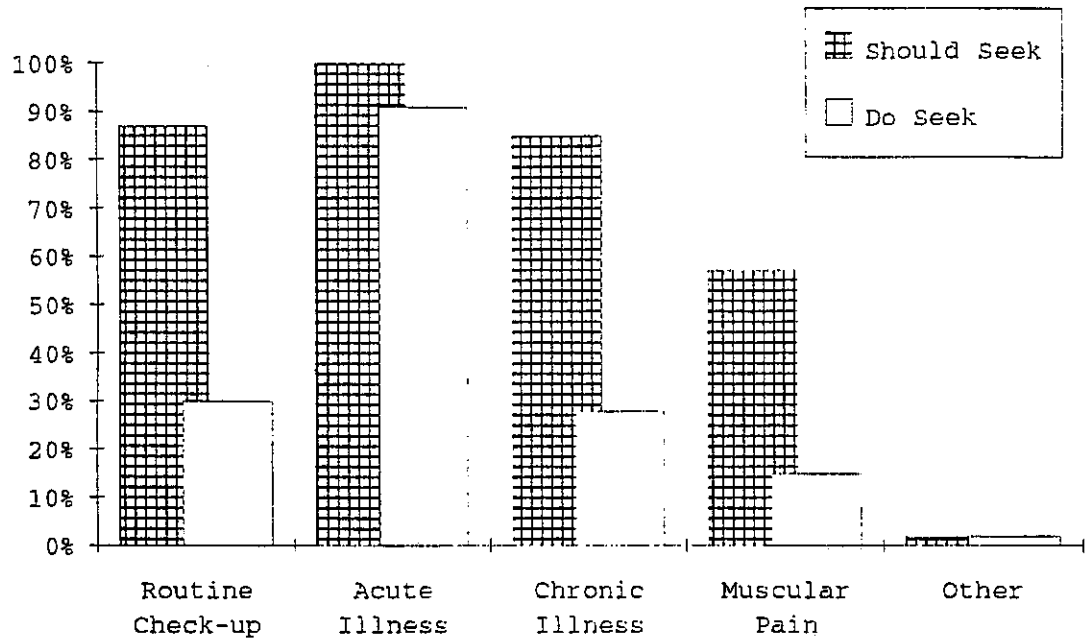


Figure 8a: Insurance Coverage: Children (n=166)

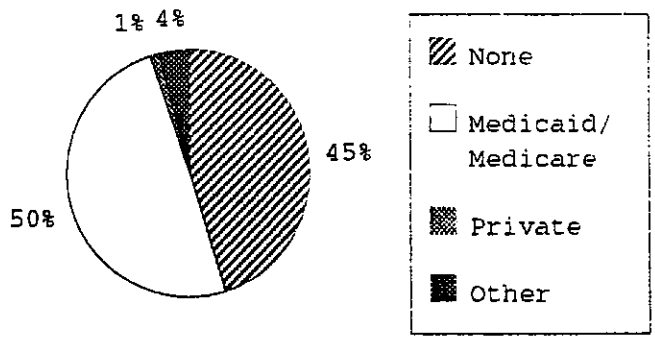


Figure 8b: Insurance Coverage: Adults (n=92)

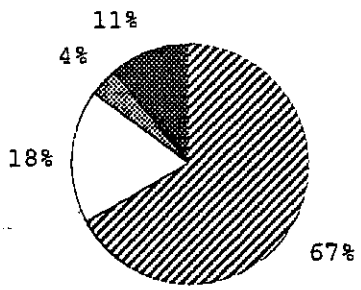


Figure 9: Binational Utilization (n=47)

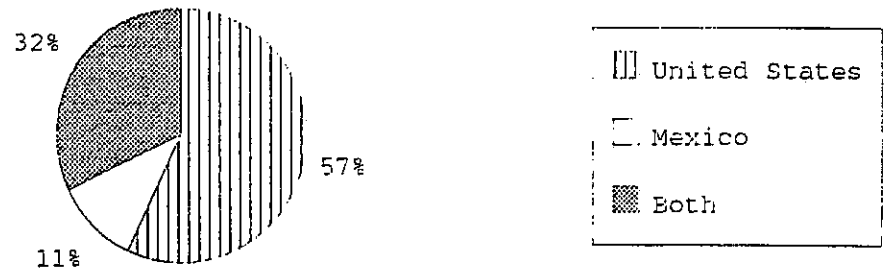


Figure 10: Providers Sought (n=47)

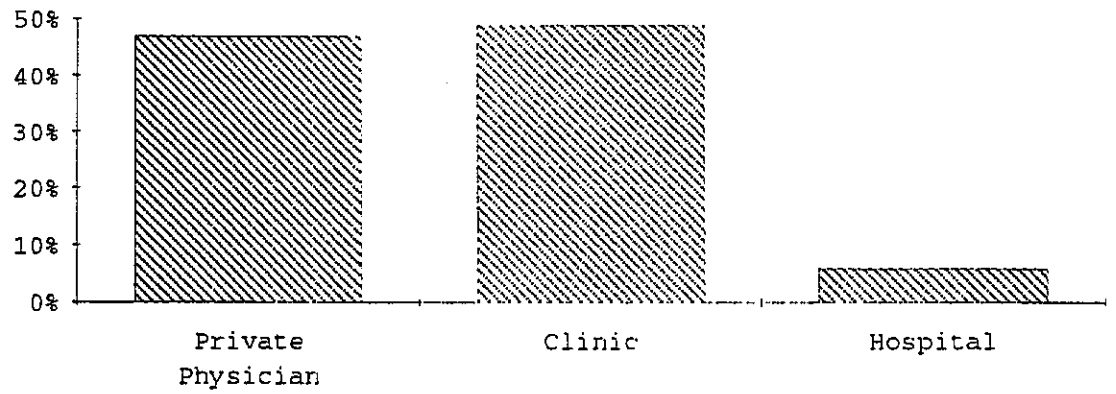
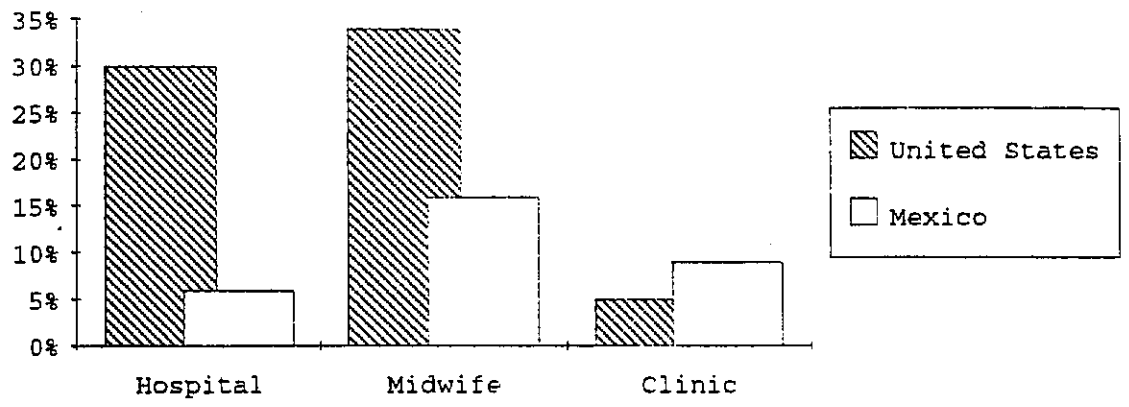


Figure 11: Country of Birth and Attendant at Delivery (n=210)



APPENDIX A

HEALTH CARE ACCESSIBILITY SURVEY

1. Sex: M F

2. Age: _____

3. Are you married?
   a. yes
   b. no

4. Do you have children living with you?
   a. yes (how many and ages)
   b. no

5. Do the children go to school (if they are school aged)?
   a. yes (where?)
   b. no

6. Do you own or rent your house?
   a. own
   b. rent

7. How many people are living in your house?
   a. 1-3
   b. 4-6
   c. 7-9
   d. 10 or more

8. How many bedrooms are in house?
   a. 0
   b. 1
   c. 2
   d. 3 or more

9. Does your home have running water?
   a. yes
   b. no

   indoor plumbing?
   a. yes
   b. no

   electricity?
   a. yes
   b. no

10. Are you eligible for food stamps?
    a. yes
    b. no

11. If yes, do you receive food stamps?
    a. yes
    b. no

12. Do you leave the area to obtain farmwork (migratory) or do you do farmwork only in this area (seasonal)?
    a. migratory
    b. seasonal (go to questions #16-18 , then to #22)

13. Do you migrate out of Texas?
    a. yes (to what state(s)?)
    b. no

14. What is the duration of your migration (per year)?
    a. 0-2 months
    b. 3-4 months
    c. 5-6 months
    d. 7-8 months
    e. 9-10 months
    f. 11-12 months

15. When did you enter the migrant stream?
    a. 0-1 year ago
    b. 1-3 years ago
    c. 3-5 years ago
    d. more than 5 years ago

16. Where are you originally from?
    a. United States (what state?)
    b. Mexico (what state?)

17. Do you have relatives in Mexico?
    a. yes (what state?)
    b. no

18. How long have you been living in the U.S.?
    a. 0-1 year
    b. 1-3 years
    c. 3-5 years
    d. more than 5 years

19. How long have you been living in this homebase area?
    a. 0-1 year
    b. 1-3 years
    c. 3-5 years
    d. more than 5 years

20. When you travel, who do you travel with? (circle *all* that apply)
    a. alone
    b. with spouse
    c. with children
    d. with other extended family members
    e. with others (friends/neighbors/etc.)

21. If you are traveling with family members, do any of them work? (circle *all* that apply)
    a. none
    b. all
    c. spouse
    d. child(ren)
    e. other extended family members

22. When you are ill, do you seek medical attention?
    a. yes
    b. no (why not?) (gp to question #25)

23. Do you go to: (circle *all* that apply)
    a. private physician
    b. clinic
    c. hospital
    d. other

24. Where do you seek medical attention?
    a. U.S. (for migratory, find out what state and name of facility)
    b. Mexico

25. Under what circumstances do you think medical care should be sought? (circle *all* that apply)
    a. routine check-up (ie: prenatal, annual physical, etc.)
    b. acute illness (ie: ear infection, bladder infection, pesticide exposure, etc.)
    c. chronic illness (ie: diabetes, hypertension, etc.)
    d. muscular pain/discomfort
    e. other

26. Under what circumstances do you actually seek medical attention? (circle *all* that apply)
    a. routine check-up (ie: prenatal, annual physical, etc.)
    b. acute illness (ie: ear infection, bladder infection, pesticide exposure, etc.)
    c. chronic illness (ie: diabetes, hypertension, etc.)
    d. muscular pain/discomfort
    e. other

27. What medical services do you know of that are available to you?
    a. private physician
    b. clinic
    c. hospital
    d. other

28. What type of medical insurance do you have?
    a. none*
    b. Medicaid
    c. Medicare
    d. private
    e. other

29. If no insurance, why not?
    a. ineligible
    b. can't afford
    c. don't want
    d. uninformed as to how to obtain

30. What medical problems have you had in the past two years?
    a. routine check-up (ie: prenatal, annual physical, etc.)
    b. acute illness (ie: ear infection, bladder infection, pesticide exposure, etc.)
    c. chronic illness (ie: diabetes, hypertension, etc.)
    d. muscular pain/discomfort
    e. other

31. Did you seek medical attention?
    a. yes
    b. no

32. If yes, how much were you charged for the services?
    a. no charge
    b. insurance paid in full
    c. $0-50
    d. $51-100
    e. $101-250
    f. greater than $250

33. How many times in the past two years have you visited a health care provider?
    a. 0
    b. 1-3
    c. 4-6
    d. 7-9
    e. 10 or more

34. How much have you paid out-of-pocket for medical care in the past year?
    a. 0-$50
    b. $51-$200
    c. $201-$400
    d. greater than $400

35. Where were your children born?
    a. United States (what state/facility?)
    b. Mexico (what state?)

36. Were you charged for this?
    a. yes (how much?)
    b. no

37. Did you receive prenatal care?
    a. yes (where?)
    b. no

38. What problems do you see with medical care presently?

39. What concerns do you have about medical care?

40. What possible improvements do you think are necessary?

41. Are you aware of others who have medical problems that are not being taken care of?

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