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Migrant and Seasonal Farmworkers: Health Care Accessibility

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> "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

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.

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.

(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

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

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

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.

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

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

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

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

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

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

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

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

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.

Migrant Health Centers Funded Through PHS Section 329

Migrant Health
Rockville,

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Figure 5: Migratory Labor Participants (n=47)

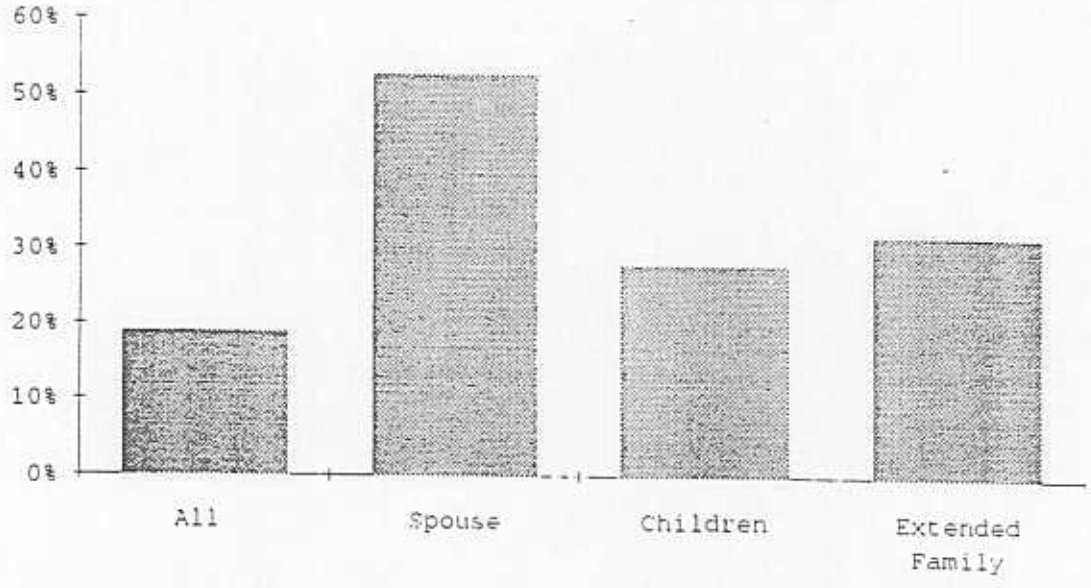


Figure 6: Duration of Yearly Migration (n=47)

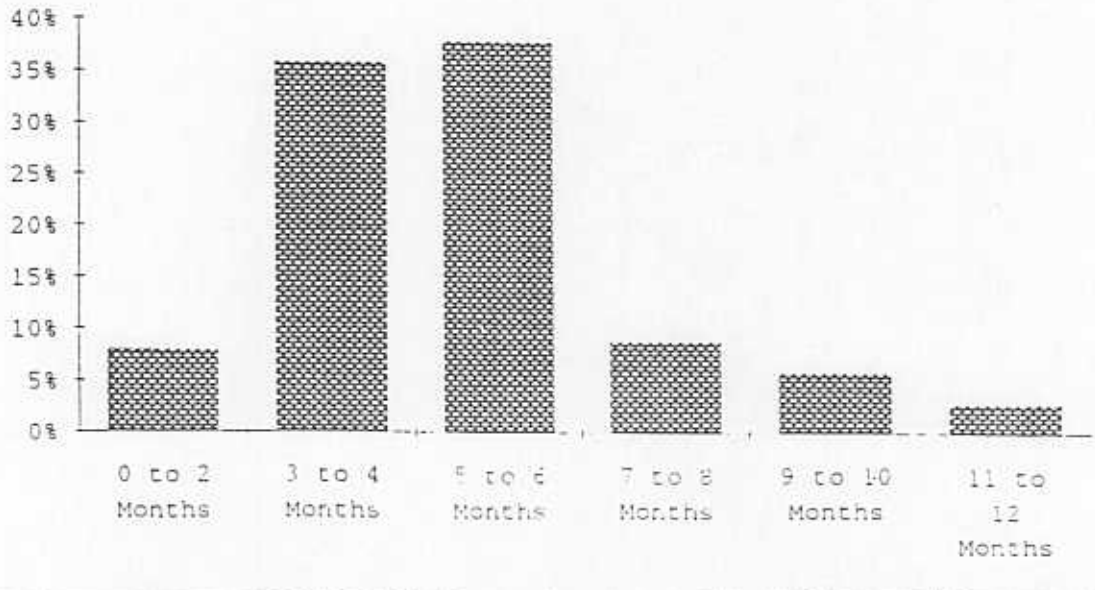


Figure 9: Binational Utilization (n=47)

Figure 10: Providers Sought (n=47)

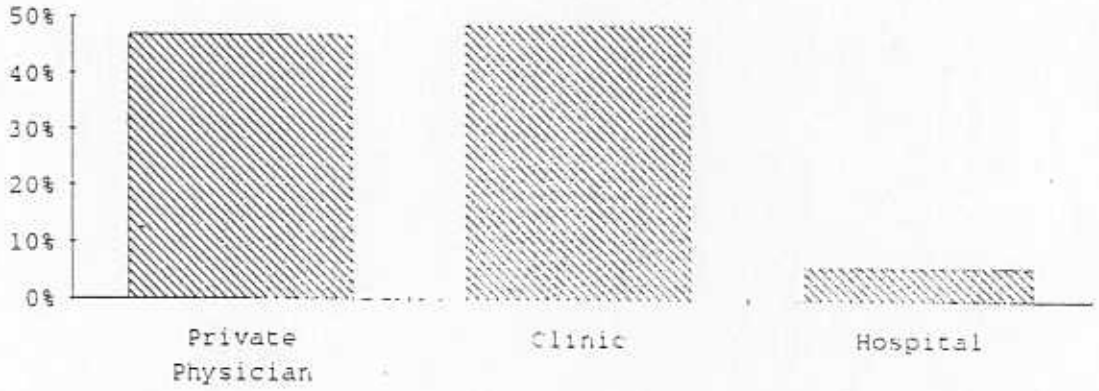
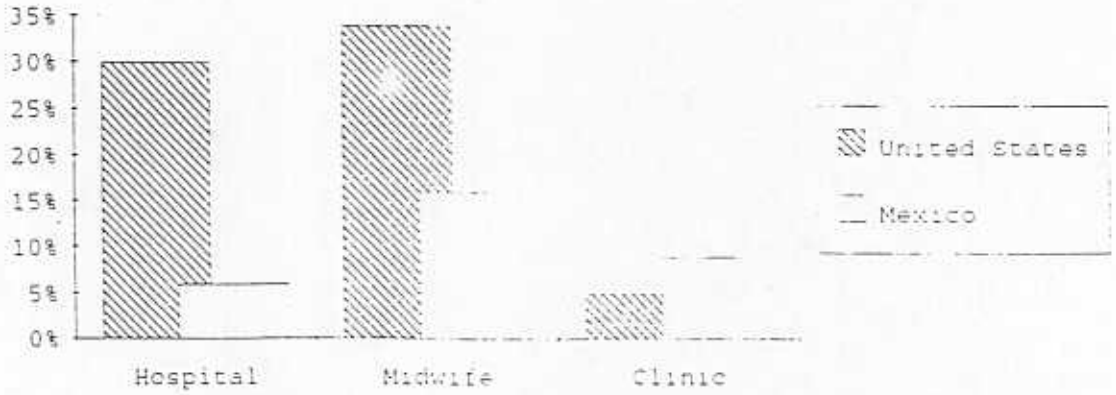


Figure 11: Country of Birth and Attendant at Delivery (n=210)



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 #13-18 , 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?)

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

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