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The Children's Health Initiative and Migrant and Seasonal Farmworker Children:

The current situation and the available opportunities

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Division of Community and Migrant Health
Bureau of Primary Health Care
Health Resources and Services Administration
U.S. Department of Health and Human Services

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The longest day in the field is when we pick strawberries. I feel bad because it gets dark. We are there so long. My body gets tired, and when its muddy, it's hard to walk. Also, my uncle has to park the truck far away and I get tired and cold when I have to walk back to the truck.

José Luis Ríos, Age 8

We go to the fields and weed and pick. It's hard because we don't eat until we get home. Sometimes I like for school vacation to be over so we don't have to go to fields.

Luisa Cervantes, Age 11

I. The Children ' s Health Initiative:

A. In the Balanced Budget Act of 1997, Congress established a goal to reduce the number of uninsured children in the United States from 10 million to 2 million by the year 2002 through the Children ' s Health Insurance Program, Title XXI. Twenty four billion federal dollars over the next five years has been allocated for this effort. [1]

B. For this goal to be met, the estimated 1 million Migrant and Seasonal Farmworkers children must be thoughtfully included in the strategic plans of state and federal government. [8]

II. The Population the Migrant Health Program serves:

Profile of Migrant and Seasonal Farmworkers (MSFW):[8]

- There are approximately 3-5 million MSFWs in America ' s fields every year [2,11]
- Their average income is less than $7500 per year
- Their median educational level is only 6 years of schooling
- About 80% are Latinos or of Latin American ancestry
- 2/3 of all farmworkers are less than 35 years of age
- 66 % of farmworker parents have their children with them
- 63 % of adult farmworkers are legally authorized to work
- 500,000 MSFWs are served by Community and Migrant Health Centers annually

The Mission:

The Migrant Health Program, part of the Division of Community and Migrant Health, works to provide access to comprehensive primary care services with a culturally sensitive focus to migrant and seasonal farmworkers and their families through Migrant Health Centers and supporting agencies throughout the country.

(For the legislatively defined population served see appendix A.)

III. The Children served by Migrant Health Centers:

Profile of Migrant and Seasonal Farmworkers Children:

- Approximately 70% of MSFW children ' s families live below the poverty line
- An estimated 43,000 children accompanied by family members and an additional 55,000 unaccompanied minors are involved in farm labor [8]
- Of the MSFWs served by Community and Migrant Health Centers, approximately 45% are children (For a breakdown by age, see Appendix B)
- An estimated 250,000 children migrate each year and approximately 90,000 of them migrate across an international border [8]

A. Health Insurance/Access Status of Children:

- 72.8% of migrant children are completely without health insurance [9]
- Migrant Health Centers provide accessible care but only have the capacity to serve fewer than 15% of the nations MSFWs [4]
- The current state-level structure and organization of Medicaid, which restricts its use outside of a particular state, hinders access to health care even for migrant children who are insured in a particular state. [9]

B. The Health Problems of Children:

1. **Infectious disease:**
   The demographic patterns in Migrant home-base communities are typical of a developing country, associated with infectious disease cycles. Generally, there is a high proportion of younger people and a low proportion of older people.

   - One study found, 34% of migrant children are infected with intestinal parasites, severe asthma, chronic diarrhea, Vitamin A deficiency; chemical poisoning, or continuous bouts of otitis media leading to hearing loss. [5]

2. **Perceived Health Status:**
   The health status of migrant children, as perceived by their primary care giver, is worse than that of non-migrants.

   - Primary care givers rated their Mexican American migrant children 2-3 times more often than care givers of Mexican-American non-migrant children to be in poor or fair health [rather than good or excellent] (15.4% vs. 5.9%). [9]

3. **Incidence of Acute Conditions:**
   The overall number of acute conditions suffered by migrant children is higher than in non-migrant children.

   - A study by the Migrant Clinicians Network found statistically significantly higher incidence of newborn conditions as well as disorders and diseases of the ear nose and throat in migrant communities than that of the general U.S. population. [2]

4. **Pesticide Exposure:**
   Children work and play in the fields, and thus are exposed to the same occupational hazards as adults. Evidence has show that children are more susceptible than adults to the toxic effects of pesticides due to their lower weight and higher metabolism. One study found: [7]

   - 48% of children had worked in fields still wet with pesticides
   - 36% had been sprayed either directly or indirectly by drift
   - 34% of the children's homes had been sprayed in the process of spraying nearby fields.

C. Reasons for a Medical Visit:

A study by the Migrant Clinicians Network found the following reasons were the primary cause for seeking care for farmworker children.[2]

Age Group	Main Health Issue Resulting in a Clinic Visit at a Community and Migrant Health Center (C\MHC)[2]
<1 year	Newborn complications, well baby check-up, upper respiratory tract infection, otitis media, other infectious disease, and nutritional problems
1-4 years	Health maintenance, otitis media, other infectious disease, and nutritional
5-9 years	Health Maintenance, otitis media, dermatological, parasitic problems, other infectious disease, and dental diseases
10-14 years	Dental diseases, acute conjunctivitis, contact dermatitis, other infectious diseases, respiratory problems, and work related conditions
15-19 Girls:	Pregnancy, dental problems, diabetes, health maintenance, other infectious disease
Boys:	Dental diseases, contact dermatitis, health maintenance, other infectious disease, respiratory disease, and work related conditions

IV. Barriers to Access

"Migrant laborers often are living by survival economics, and are geographically isolated from treatment centers. Money, time off required from work, and lack of transportation, combined with linguistic and cultural disparity, are the most effective barriers to health treatment which farmworkers face."
-1995 Recommendations of the National Advisory Council on Migrant Health[4]

A. Poverty

The most extreme barrier to well being for the children of farmworkers is the extreme poverty of their families.[8]

B. Lack of Insurance

By income standards, the vast majority of migrants would be eligible for Medicaid. However substantive barriers include:[9]

- Individual state regulations and applications for Medicaid
- Daytime Medicaid office hours
- Short length of stay in most states
- Lack of appropriate documentation
- Lack of portability from state to state

C. Social, Environmental, Ethic/Racial

Social, environmental and ethnic/racial factors associated with farmworkers appear to interact in a way that produces greater risk to health.[9]

D. Immigration Status

Particularly in recent years, many families of MSFWs include individuals with varying immigration status. This can lead to a fear of seeking publicly funded services unless it is made clear that this will not put them at risk of compromising their eligibility for citizenship or of deportation.

E. Geographic Isolation

Rural isolation and inadequate transportation are major factors that have been found to affect access to health services, even when financial barriers are removed.

V. The Migrant Health Program Response to Access Barriers

A. Poverty

The Migrant Health Program provides primary care services to children regardless of their ability to pay.

B. Lack of Insurance

The Migrant Health Program provides primary care services to children regardless of their insurance status.

C. Social, Environmental, Ethic/Racial

The Migrant Health Program provides primary care service in settings that are culturally, linguistically and educationally appropriate, as well as being accessible to where farmworkers live and work. Outreach services provided by centers take health care and preventive services into migrant camps and work with local partners to reach farmworkers in the places that they naturally gather. Outreach services have also included the training of farmworkers themselves to be lay health advisors for their own communities.

D. Immigration Status

The Migrant Health Program provides primary care services to farmworkers and families that are in need of medical services, regardless of their immigration status. This is in the best interest of those receiving care and those residing in the communities where farmworkers live and work. This policy is also in the best interest of the American public who consumes the food that the farmworkers plant, prune and harvest.

E. Geographic Isolation

The Migrant Health Program provides primary care services to farmworker children and families in ways designed to overcome geographic isolation, which is confounded by their mobility and their lack of transportation. Migrant Health Centers have a history of service and the staff knows the backcountry roads and locations of migrant labor camps that most people never notice. They also know the seasons of the crops and when farmworkers and their families will be in their service area. Many health centers have relationships with growers and are allowed to enter private property in order to provide

greatly needed services.

VI. RECOMMENDATIONS for the Children ' s Health Initiative:

In order to reduce the number of uninsured and underserved farmworker children, special consideration must be given to their unique needs. The following recommendations would begin to address these needs.

A. Allocation of Title XXI Funds to Increase Access to Community and Migrant Health Centers

> *"Migrant Health Centers offer culturally and linguistically competent services. I've seen parents go many miles out of their way to seek health services for their children in a friendly environment."*
>
> *- Rachel Gonzales, Executive Director, Uvalde County Clinic*

Section 2105 of Title XXI legislation allows States to submit a request for waivers which could allow the use of Children ' s Health Insurance Program funds for coverage of children, *"provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act."* [12]

Approximately 750,000 uninsured children throughout the Nation currently use Community and Migrant Health Centers (C/MHCs) as their primary source of health care.[1] A Congressional Research Service study found that use of C/MHCs as a regular source of care by uninsured children would double if the number of C/MHCs were increased by only 60%. [1] In addition to increasing the number of C/MHCs, some other ways to improve access to care for uninsured children are:

1. Increasing Outreach Service Delivery Capacity:

In health center catchment areas, outreach is one of the most effective ways to identify and treat migrant children with health needs, including needs for acute care and preventive services. Enrollment in either Medicaid or CHIP would allow these children to have a method of payment, which would increase the medical options available for necessary specialty and sub-specialty care.

Section 2102 of Title XXI legislation encourages States to continue their current outreach and enrollment efforts and to increase them by using Title XXI funds for, *"outreach to families of children likely to be eligible for child health assistance under the plan or under other public or private health coverage programs to inform these families of the availability, and to assist them in enrolling their children in, such a program."* [12]

2. Increasing Linguistic and Cultural Competency:

Multi-lingual services of are necessary in the vast majority of Migrant Health Centers. Recently many communities have begun to see greater numbers of

families from rural Mexico and Central America who speak dialects unknown even by bilingual (Spanish/ English) staff. [6]

3. **Increasing Medical Records Transfers:**
Due to a lack of a national medical records transfer system and the mobility of farmworkers, the Migrant Clinicians Network reports that there is probably no other population in the United States that has had simultaneously high incidences of both-over immunization and under immunization in children.

4. **Environmental Health Programs:**
Issues concerning the lack of potable water, sanitation services in the fields, pesticide exposure, and housing must be addressed via health centers in order to provide comprehensive primary and preventive care.

B. Title XXI and Medicaid Reciprocity Models

"We see a lot of children from the South. Many of them have Medicaid in their home state, but there 's no reciprocity agreement for serving between their state and Maryland. So the kids don 't have Medicaid coverage during their stay here"
- Sister Eileen Eager, Delmarva Rural Ministries

Wisconsin operates a Medicaid reciprocity system in which MSFWs and their family members, presenting a valid medical assistance card from any other state, automatically qualify for Medicaid in Wisconsin. They need not re-establish their eligibility in Wisconsin in order to receive services. Additionally, income measurements used to establish eligibility utilize an averaging technique such that higher income months for farmworkers do not disqualify them for assistance if they would qualify based on their annual income.[10]

C. Presumptive Eligibility for Title XXI Services

Farmworkers and their children often wait until acute incidences in order to seek medical attention. They need to be able to receive services at the first point of contact and not to be told to wait until they are eligible to receive those services. Section 4912 of Title XXI legislation states, *"a State plan approved under section 1902 may provide for making medical assistance with respect to health care items and services covered under the State plan available to a child during a presumptive eligibility period."*[12]

D. Target Title XXI Funds to the most Economically Disadvantaged Children

The Conference agreement of Title XXI legislation states that the eligibility standards for the Children 's Health Insurance Program, *"could not, within any defined class or group of covered targeted low income children, cover children with higher family incomes before covering children with lower family incomes."*[12] Therefore MSFW children, 70% of whom live under 100% of the poverty line, should be some of the first children to be included in state plans. It is imperative that states be encouraged to prioritize serving these children

who are the poorest of the poor in this country.

E. Incentives for Serving MSFW Children

Often the most effective means to accomplish goals is through the use of incentives. This is particularly true with national goals that can goals that can only be reached through state level policies. The use of incentives to provide for the health needs of MSFW children would be in the best interest of both the population and of the general public health of American people.

APPENDIX A

Legislatively Defined Population served by DHHS:
Defined for DHHS by PL-104-299 as, Migrant and seasonal farmworkers workers (MSFW) and members of their families who reside in the defined catchment areas and individuals who due to age or disability no longer migrate for agricultural work and their families.

Migratory Agricultural Worker is defined as, "an individual whose principle employment is in agriculture on a seasonal basis, who has been so employed within the last 24 months, and who establishes for the purposes of such employment a temporary abode."

Seasonal Agricultural Worker is defined as, "an individual whose principle employment is in agriculture on a seasonal basis, and who is not a migratory agricultural worker."

Agriculture is defined as, "farming in all its branches, including: cultivation and tillage of the soil; the production, cultivation, growing and harvesting of any commodity grown on, in, or as an adjunct to the land; and any practice performed by a farmer or on a farm incident to or in conjunction with the above stated."

APPENDIX B

Percent of MSFW Children Served at Migrant Health Centers by Age Group (years)*					
	< 1	1 - 4	5 - 12	13 - 14	15 - 19
% of Total	7.5	27.0	38.6	7.4	19.5

* Derived from Sample Data of 17 Migrant Health Program Sites.

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