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MIGRANT CLINICIANS NETWORK

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Dreaming the Right Dreams, Part Deux

By Mark Koday, DDS, Dental Director, Yakima Valley Farm Workers Clinic, Toppenish, Washington

The term "health care reform" conjures up as many images as there are people that think about it. In the public arena it is a chameleon-like creature that seems to change on a daily basis. The only things most people would probably agree on is that health care reform, in one form or another, is inevitable and needed. Those of us in migrant/community health clinics (M/CHCs) see the results of a woefully inadequate health care system on a daily basis. While most people talk in theory about our health care crisis, we are engulfed by its reality.

Dentistry is a particularly unique part of health care reform. I don't believe many people outside the dental profession have a comprehensive understanding of where dentistry fits into the overall health care scenario. This is especially true when we try to convey the devastating effects of poor oral health on the communities we serve. In the world of health, dentistry is a lot like the neighborhood stray dog that everyone thinks is cute and lovable but no one wants to pay to have properly fed or groomed. We're considered an annoying nuisance when we howl for funding. Even in the public health arena, competition for dwindling dollars puts medical, dental, and other health concerns in adversarial positions. Within dentistry itself, public health versus private practice issues can often cause division and conflict. Unfortunately in health care reform, there are few clear cut choices that everyone will agree on.

For those of us in M/CHCs, the question we must ask is "what role do we play in health care reform?" I believe the answer is clear and simple. As clinicians we are the local experts and it is not only our right but our responsibility to advocate for our patients' health care concerns. We cannot hide in our clinics while the storm of health care reform swirls around us. To do this would be a major disservice to our patients. While we are very fortunate to have excellent advocates for our patients' needs on the national level, we must be ready to fill that role on a local and state level. As you know, many states are not waiting for national reform; they are proceeding on a fast track to change their state's health delivery systems. In those states, if we don't represent the needs of our patients, who will?

As public health dentists, we can provide a powerful voice and affect positive change but it does require a good deal of effort on our part. The following are some considerations you may need to address as you position yourself in this advocacy role.

1) ***Educate Yourself on the Issues:*** If you are going to be a spokesperson for your community, you need to be knowledgeable of all the issues. Read and understand the proposed Health Security Plan. Find out what dental coverage there is in the basic health package. Find out what the U.S. Public Health Service is recommending for coverage. Read the position papers of the Migrant Clinicians Network and the National Network for Oral Health Access (NNOHA). These organizations and others are strong advocates for our patients. Check out what the American Dental Association (ADA) and your state dental society think about health care reform. Most important, you need to keep aware of what is happening on the state level.

2) ***Become a Local Expert:*** As the health care debate heats up in your state, local data becomes critical. If you have any dental disease data, published or unpublished, make it known to everyone. I can't emphasize this enough. Without local data to show the high disease rates in our communities, the only data most states can use is from the National Oral Health Surveys which show that dental decay is no longer a major problem in our nation's children. If you don't have a university library nearby, use the ADA Package Libraries Service. You will be surprised how eager people are

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How the Clinton Health Care Plan Affects Farmworkers

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The Clinton Administration's proposal for national health reform is laudable and long overdue. Its assurance of nearly universal coverage for a substantial list of benefits comes far closer to assuring the nation of health care as a right, not a privilege, than many others of the proposed plans now being seriously contemplated.

There are three primary ways in which the plan can have adverse consequences for farmworkers, however, and additional problems which farmworkers will have as will others.

Universal Coverage

First, the plan excludes undocumented aliens. As most undocumented persons are in low-wage jobs, health care coverage is seldom employer-provided even now; little if any is provided to those in farm work. A fortunate 15% of these persons are cared for at migrant health clinics, which provide care to all seeking their services, applying only an income test to determine appropriate payment. However, this network — although nationwide — is not a large one, and cannot reach every farmworker who needs medical care. Outside of these clinics, undocumented persons will have precious few options for covered care. As a consequence, they can be expected to postpone seeking care long after medically indicated, may not find it, and — as again is too often the case today — will have to depend on emergency rooms.

Portability

The second primary problem with the plan, for farmworkers, concerns portability of coverage. It limits to six months out-of-area coverage for enrolled persons, and, much worse, that care is not for the full range of benefits in the plan but only for emergency care. A substantial portion of farmworkers who migrate may be away from their home areas for more than six months; certainly for their entire time of migration each year they need access to full, comprehensive primary care services. For this population, with structured, annual travel, this limit should be raised to a full year, and out-of-area benefits should be made comparable to plan benefits available to anyone.

Reimbursement Mechanisms

The third main problem with the plan for farmworkers (and others as well) centers around the dubiousness of four of its proposed provisions for protections for the currently underserved: a) its stipulation that *seasonal workers* pay both the employee and the employer share of the premium; b) provisions that low-income persons are to benefit from a premium *subsidy;* c) its proposal to provide federal standards for payment *rate adjustments* for hard-to-reach populations; and d) its proposal to *phase out present categorical programs* that now serve such populations, and phase in payments to local providers to begin such services. These concerns are outlined below. Unless they all work, farmworkers could be severely disadvantaged.

a) Most part-time and seasonal work is exempt from employer premium payments under the Clinton plan. In a regular pattern of labor like migrant farm work, it is inequitable not to share some of the burden with growers. The State of Washington, for example, has developed an employer pay-in pool concept as an amendment to its reform legislation, which could well serve as a model for the nation.

b) Premium subsidies proposed in the Clinton plan cover only compen-

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to receive this information. If you're not sure where to send this information, try your state's dental officials, your state public health association or regional community clinic association.

3) ***Analyze the Effect Reform Will Have on Your Patients:*** In the state of Washington, the basic health care package may only include preventative services. Currently, the majority of my children patients are covered by Medicaid, which includes all the services they need. Medicaid will eventually be rolled into the basic health care package, meaning that the state's most vulnerable population will lose restorative services. With this scenario, health care reform will prove disastrous for our patients.

4) ***Analyze How Reform Will Affect Other Organizations:*** Find out the effects on M/CHCs, Headstarts, and local schools. It is important to remember that while these groups may be knowledgeable of how the medical side will be affected, they often do not have the dental side properly reviewed. These organizations can use your expertise and information, and can also be a powerful lobbying force.

5) ***Position Yourself in the Health Care Debate:*** Let your clinic administrator know you want to be a part of the process. Find out what advocacy groups exist or may be forming. Apply for positions on advisory groups. There are not many of us out there so you may be surprised how eager groups are for your input.

Even on the state level, health care reform can involve the shifting of millions if not billions of health care dollars. Dentistry is such a small piece of this that we are in real danger of being swept to the side and ignored. We have worked too hard and our patients have suffered too long to allow this to happen. ❖

An Excerpt From

"Migrant Health: *A View from the Frontline*"

By Francis J. Stilp, RN, FNP, Southeast Georgia Migrant Health Program, Metter, Georgia

I am writing this paper because I am frustrated and angry from years of begging for funds and services, tired of the *status quo*, and chronically exhausted from the struggle to provide health care to migrant and seasonal farmworkers and their families.

I want justice for these valiant people who bring food to our tables. And I want relief from the onerous bureaucratic red tape required to provide services to them. In short, I want to change the system!

I was sitting at my desk in the migrant clinic at Nueva Vista camp near Lamar, Colorado, in the southeast corner of the state. It was September 1988. I was trying to figure how I could have a migrant woman see a gynecologist. The woman had a class II PAP and needed a culposcopy. The nearest OB/GYN, 60 miles away, wanted $300 up front to see my patient. Their office told me to expect a bill of $800 if cryosurgery was necessary. This patient's abnormal PAP was over a year old and I was worried about her. She was afraid to go to the doctor.

Just then a B-1 bomber flew by the camp on its low-level training mission. This single airplane, at a cost of $100 million, was worth over twice as much as the yearly national budget ($44 million) for the Migrant Health Program. "Just one of those planes a year would double the capacity of migrant health," I thought.

My work with the National Migrant Resource Program in the spring of 1988 had made me a student of health care policy and I was anxious to see if any progress had been made during my 10-year absence. What I found made me sad. Where before there was a Headstart/daycare center, there was none. It had closed five years earlier. At the migrant clinic there used to be a full-time registered nurse to coordinate care; now a nurse was present for two months of the year. Important health care decisions are now made by outreach workers. Reaganomics had a negative impact on the Migrant Health Program.

Over the recent past the minimal increases in funding have not even kept pace with inflation, resulting in a decreased capacity to serve this population. It's no wonder that we only reach approximately 15% of eligible migrant/seasonal farmworkers. The Migrant Health Program, after 32 years, occupies a nearly insignificant corner in the giant Department of Health and Human Services. It has been inadequately funded throughout its history.

I had been a fighter pilot in the Navy and flown commercially. As an airline pilot I flew internationally, and saw the conditions that much of the world's population suffers. When I was furloughed I elected to turn from flying and struggled for some time for direction. I eventually decided that I wanted to pursue a helping profession and ended up going to nursing school in Denver. I knew that I wanted to work with disadvantaged people and jumped at the opportunity for a rotation in migrant health. I was hooked and began my work in migrant health in Colorado in January 1977.

As a student of health care reform I strongly support the adoption of a single payer system. This system, used by Canada, is the only way to capture the waste, excess profits, and fraud extant in the U.S. and turn it into coverage for all while, at the same time, remaining competitive in the international marketplace. Failing the adoption of such a system, legislation must allow states that option, as I believe demonstration will prove its efficacy.

No matter what reform becomes law, it will be unacceptable unless migrant/seasonal farmworkers, including illegal aliens, have the same coverage as all Americans plus the ancillary services of translation, transportation, and case management. We've had a second class health program for 32 years; it's time for health equity for farmworkers.

In the event that health care reform is delayed or fails to become law, I suggest the following steps to reform the Public Health Service system:

1. Instead of the numerous 329, 330 and 340 grantees presently existing, funds would be granted to state primary care associations, which would flow them to the centers in their states. Grants to the associations would be for three-to-five year periods and would not have to be submitted on an annual basis. The Migrant Health Program must achieve funding parity ($10 million) with the community health centers; and an equitable formula for funding must be instituted.
2. Every effort should be made to have each MHC dual-funded in order to abate local community objection and to integrate health services for migrants into the general populace while retaining ancillary services.
3. Grants to individual grantees should be for a minimum of $400,000. Grants to statewide programs should be a minimum of one million dollars. No new starts should be funded until funding equity is achieved nationally and all current programs reach the above levels.
4. Programs should be required and funded to have a minimum of one bilingual outreach worker per county in their service area.
5. Close the regional offices of HHS and move the funds to the front line where they belong.
6. Centers would no longer have an executive director. The executive

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Clinton Health Care Plan

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sation up to the cost of the lowest-cost care plan available in the area, thus consigning low-income persons to public-clinic model plans. These plans will be least likely to offer freedom of choice in provider selection, additional services at cost if desired and affordable, and greater convenience in hours and location. Moreover, there is no guarantee that low-cost plans will be convenient to farm housing and working areas.

c) The plan contains proposals for payment adjustments from the alliances to the provider plans to compensate for care given farmworkers in excess of the standard benefits package amounts. Such national rate adjustment calculations have long been proposed as an equalizer of access to care, but are very cumbersome to implement. Substantial delays, errors in eligibility and improper application of adjustment factors could easily ensue.

d) Another problem concerns the plan's lack of clarity concerning the role of current federally-funded programs like migrant health clinics. It notes the need for "enabling services," and acknowledges a category of providers — undefined at present — labeled "essential community providers," who presumably are those which can best provide the enabling services. It calls for alliances and plans to contract with these providers for the time being, and refers to new funding for the development of a capacity to provide enabling services by others. Essential providers like migrant health clinics are in place now.

Budget analyses being developed to accompany the plan show *substantial cuts (50%) in the size of the existing Community and Migrant Health Center programs at once* when the plan begins, under the rationale that many of their patients will now be able to get care anywhere. If these programs are cut, although state programs may take years to phase in completely, where will our clients go except... emergency rooms.

Allowing alliances to stop contracting with essential providers in a few years, presumably after developing enabling services capacities of their own, will jeopardize even the meager access to care for farmworkers even available presently through the migrant health clinics.

In summary, while the goals of the Clinton Health Security Act are sweeping and welcome, adjustments are needed to truly make the plan work for farmworkers. As Congress tackles the issue in 1994, there is no guarantee that the President's plan will prevail. All friends of farmworkers must remain alert and convey at every opportunity to policymakers the true needs of those we serve, so that no plan can pass unaware of these needs. ❖

View from the Frontline

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director would be at the primary care association. The medical director would oversee the center.

7. Pass legislation permitting mid-level practitioners to practice independently.
8. Business activities common to all centers would be performed at the primary care association (payroll, billing, accounts payable, etc.). Communication would be via computer modem.
9. Supplies and drugs would be purchased in bulk by the association and distributed to the centers.
10. Software would be developed to do all accounting, reporting and patient tracking/data transfer required. The same software would be used by all centers nationwide.
11. Quality assurance audits would be performed by teams out of the associations.

These 11 steps, utilizing business principles, would result in a considerable savings of dollars through economy of scale. They would reduce the level of stress and administrative workload so that we could concentrate on the provision of excellent care to our patients.

The *Harvest of Shame* has continued in our nation for nearly one hundred years. Justice for farmworkers is long past due. If I had the power no crops would be harvested until justice for these people is achieved. To those who read this paper, I charge you with the obligation to work for justice for farmworkers. ❖

"The greatest sin is to exploit your fellow man... the purpose of life is to fight that exploitation." —*Edwin L. Cobb*

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