Barriers to Healthcare Persist for Migrant Farm Workers

By Glenn Bunnell
Staff Writer

Despite the federal government's 30-year support for migrant health; despite its enactment of the 1997 State Children's Health Insurance Program (S/CHIP); despite widespread efforts by the National Center for Farmworker Health (NCFH) to remove obstructions and boost participation in healthcare programs for migrant farm workers, barriers persist. Roberta 'Bobbi' Ryder, CEO of NCFH, said that only 600,000 of the 3.5 million or more migrant and seasonal farmworkers are being treated in migrant health centers. Many of those needing, but not seeking, care defer because they lack the money to pay for treatment, or do not have insurance. Ryder is disheartened when she estimates that of the 40 to 60 percent of these farmworkers who are eligible for the federal safety net insurance programs (S/CHIP, Medicare, and Medicaid), less than five percent are actually participating. She blames the low percentage of participation on "administrative access barriers to the programs."

Ryder offers a scenario she deems typical of what the farmworker faces. A migrant, home-based in Texas, becomes eligible and applies for Medicaid during the late-winter months. After enduring a several-week period of rigorous eligibility determination, the farmworker is approved and receives a Medicaid card. By now, however, it's spring, and the worker departs for Colorado to work in the spinach fields. Knowing he or someone in his family may need medical care of some sort while in Colorado, the worker applies for Medicaid in that state. The rigorous eligibility-determination process begins anew. Assuming the worker has carried proper documentation with him from his home state, by the time he is ultimately approved, chances are the spinach crop has been harvested. It's time to move on to Montana, where, of course, the worker is again uninsured. As Ryder points out, "They (the farmworkers) have to go through the process again and again. You only have to do that for one season to figure out it doesn't do you much good. So you stop doing it."

It would seem that the failure of so many migrant workers to participate in programs for which they are eligible would generate significant savings for federal and state governments. But, Ryder points out, "the constant prolonging of visits to a doctor for preventive care or for intervention on a mild problem only exacerbates the eventual bigger problem, and they end up in emergency rooms, or have to be hospitalized. And who ends up paying for the more costly care? Either the hospital or the community."

A paper prepared by Mary Kenesson, a consultant for Health Policy Crossroads, for the Center for Health Care Strategies, Inc. (CHCS), Princeton, New Jersey, summarizes the complexity of the barriers: "Eligibility policy constraints include: differences among states' eligibility policies; income computation methods that can

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disadvantage applicants with unpredictable fluctuating income; documentation needed to verify eligibility; state residency requirements; and complex policies governing citizenship and immigration. Access to the Medicaid enrollment process is also constrained by transportation and communication barriers, and lengthy processing times that can exceed the individual's stay in the local area. In many states, Medicaid eligibility also entails mandatory enrollment in managed care arrangements ill-suited to a migrant population, and managed care enrollment further complicates and extends the process of establishing eligibility."

Outside of the healthcare field, reaction to these problems is characterized by indifference. Often that indifference is attributable to an assumption that farmworkers are "illegals," here "to avail themselves of our welfare programs." Ryder points out that many people make the assumption that migrant equals immigrant, "and that's just not correct," she said. "For decades, the vast majority of migrant farmworkers have been legal residents — citizens. But the (migrant equals immigrant) assumption creates a shield for people who don't care to worry about them. Those who choose not to worry must look to other sources for justification, because 'they're not ours' is not a valid argument." According to a Natural Agricultural Workers Survey (NAWS), by 1999 an influx of immigrants had — for the first time — reduced the number of citizen farmworkers to something less than 50 percent.

Ryder suggests that those who have no interest in fixing the healthcare access problem on the basis of it being the humane thing to do might want to consider the food-safety issue. Ryder said conditions under which migrants frequently work. "If there are no handwashing facilities, no toilet facilities, and no potable drinking water, you're not going to have a very healthy farmworker," she said. "If you don't have healthy farmworkers, either because of field sanitation or because of disease, how healthy will our food source be?"

Tina Castanares, MD, is a family physician at La Clínica del Cariño Family Health Care Center, Hood River, Oregon. She deals firsthand with the special health problems of migrant and seasonal agricultural workers. She said risks that contribute to the health problems of migrant workers include: exposure to chemicals used in pesticides and to nurture the soil; legal risks, because of the limited extension of child-labor and worker's-compensation laws to farmworkers; substandard housing; and poverty and field sanitation.

Like Ryder, Castanares is concerned about the access issue. She is also concerned that immigration and welfare changes that took place in the late 1990s may worsen the access problem, especially in light of the increasing numbers of immigrants in the agricultural workforce. She said legal immigrants have to be here for five years before applying for Medicaid, and that those here illegally (and "undocumented") are not eligible at all — ever. "So," Castanares said, "here you have a workforce that's changing all the time — but still very, very poor; still with health problems — and they're increasingly ineligible for Medicaid and Medicare because of immigration and welfare law changes."

Ryder said she has narrowed her focus since starting in the migrant health field almost three decades ago. Without dismissing the need for care by immigrants, she recognizes that a federal healthcare program is probably impossible. "My focus," she said, "is on getting the farmworkers who are eligible enrolled and participating so they can take advantage of, and be covered by, the programs for which they are eligible. I'm not for healthcare reform. I'm not asking for expansion of benefits to an undocumented or even an immigrant population. All I'm asking for is that those who are eligible be allowed to participate and that we remove the administrative barriers that get in their way."

Castanares said she would like to see health problems treated as health problems and not linked to immigration status. "In other words, I'd like for people's immigration status to be irrelevant when it comes to their eligibility for care and coverage." She believes the country would be way ahead if all people of a certain income level were eligible for healthcare and health insurance, regardless of residencey status. "If you nationalize programs, even if just for migrants, making portability no longer an issue, they could go from state to state and work seasonally, but on the basis of their annual income, still eligible for help." She would also like to see "removal of all the restrictions that make farmworkers less protected people, extending to them the civil liberties and rights that we all take for granted."

Ideally, you define the problem; you propose a solution. Unfortunately, the key to solving the migrant healthcare access issue would appear to lie in engendering cooperation between states, so that eligibility requirements could be standardized and reciprocity agreements put in place to render Medicaid benefits portable. So far attempts to make that happen have failed. But you can be sure that Ryder and Castanares and others like them will keep on trying. Ryder paraphrases a challenge set forth in the Kenesson paper: "This subject has been examined, focus-grouped, studied, and researched. Will we be able to martial the forces to make changes? Do we have the collective will to fix the problem? Or are we just going to concede, 'It's too big a problem; we can't fix it?'"

If Ryder and Castanares have their way, ***it will be fixed. It must be fixed.***