The State of Health Care Services for Mobile Poor Populations: History, Current Status, and Future Challenges

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A migrant is a person who crosses a prescribed geographic boundary by chance, instinct, or plan and stays away from their normal residence to engage in remunerated activity.

The definition of *migrant* appearing above includes elements from the U.N. Convention on the Rights of Migrants[1] and from the *American Heritage Dictionary*.[2] For many in the United States, the term *migrant worker* conjures an image of an immigrant farm laborer. However, most migrants participate in multiple industries in addition to agriculture, generally low-wage and often high-risk occupations such as construction, poultry and meat processing, and domestic services. In this discussion we are concerned with this broad group of the mobile working poor, some of whom could also be referred to as *farmworkers*, as *people who are homeless*, or as *undocumented immigrants*.

The migrant workers of the United States in 2010 are members of diverse populations moving rapidly between sending and receiving locations. The migrant's temporary social and physical environments affect this or her health and well-being.[3] The occupations engaged in by migrants, as well as the fundamental factor of mobility itself, combine to create a lifestyle that carries multiple health risks. A review of the history and current status of health care services for United States migrant workers provides a glimpse into the efforts of a few to tend to the unique needs of an otherwise disenfranchised population.

History of the Migrant Health Program

In an event that is difficult to imagine in our current political climate, President John F. Kennedy signed into law the Migrant Health Act on September 25, 1962, in order to meet one of the "nation's most important health problems and to improve the deplorable health conditions of migrant workers."[4] The Migrant Health Act authorized the delivery of primary and supplemental health services to migrant farmworkers and was the beginning of national efforts to improve the health status of the mobile poor.

The Migrant Health Program is currently funded under the Consolidated Health

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Care Act of 1996 and administered by the Office of Minority and Special Populations (OMSP), Bureau of Primary Health Care (BPHC), in the Health Resources and Services Administration (HRSA), Department of Health and Human Services (DHHS). There are 156 federally-funded Migrant Health Center (MHC) entities, which in 2008 provided comprehensive primary health care to 834,000 migrant/seasonal farmworkers. Most of these organizations are jointly-funded Migrant and Community Health Centers (M/CHCs). Approximately 18 of the programs are known as *voucher programs*, a service delivery model that provides health care access to farmworkers in sparsely populated areas through outreach and referral to other health care organizations through the use of payment vouchers that help to pay for office visits. Most M/CHCs are private non-profit corporations owned and operated by community-based organizations; some are operated by governmental entities such as state and local health departments.

Collectively, these M/CHCs operate more than 500 satellite service sites, and constitute a loosely knit network of independent organizations serving migrant and seasonal farmworkers. They range in size from small clinics in frontier and rural areas that are in a given location for periods as short as two weeks to large, jointly-funded M/CHCs in high-intensity agricultural areas with tens of thousands of farmworkers served by one organization. Regardless of their setting or farmworker population size, all migrant health grantees are required to provide a standard set of primary care and outreach services. A unique feature of the M/CHC legislation that has made the model particularly responsive and enduring is the mandate that the governing boards of these entities be composed of a 51% majority of consumers of the health center's services.

Changing Demographics of the Mobile Poor

> *People are not migrants by choice. We depend on misfortune to build up our force of migratory workers, and when the supply is low because there is not enough misfortune at home, we rely on misfortune abroad to replenish the supply.*
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> —Harry S. Truman, 1951, *Migratory Labor in American Agriculture, A Report of the President's Commission on Migratory Labor,* Superintendent of Documents, U.S. Government Printing Office

Over the past several decades there has been continuous change in the composition of the mobile poor in the United States, shifting with world politics and economics. Changes occur in both the demographics of the population and the types of work in which they engage. Traditionally, the majority of the mobile poor have been recent immigrants to the United States, a group typically willing to accept any type of labor that will contribute to the support of their families. From the 1960s to the late 1980s, the migrant population on the East Coast and Midwest included a mix of African American, Latino, and Haitian workers, while on the West Coast it mostly included Latinos. In recent years Latinos (from Mexico and Central America) make up the vast majority of the migrant workforce, though there are locations where growing numbers of Latin American indigenous, Asian, or Caribbean workers predominate.[5]

Migrants work in the jobs known as *3D—dirty, dangerous, and demanding*,[6] or as *SALEP*—jobs that are *Shunned by All Except the very Poor*.[7] With the growth of large

agribusiness, increasing numbers of farmworkers are moving from small fruit orchards and vegetable crops to settings such as confined animal feeding operations (CAFOs), as well as meat-packing and other food processing plants. A need for low-wage workers in newer migratory industries such as landscaping, forestry, nurseries, construction, fisheries, restaurants, hotels, and factory and warehouse work has also developed.[8] The reality is that this new migrant labor force has a tendency to move in and out of jobs depending on the local need. In their search for a better life for their families they may move several times and work in many jobs before they are able either to secure a steady job and settle in an accepting community or to save enough to return to their home country to begin a new life there.

Current Status of Health Care for the Mobile Poor

The nation's network of federally-funded MHCs provides services to migrant patients in the context of primary care settings that have been designed to provide culturally competent care regardless of patients' ability to pay or immigration status. Most utilize care delivery models appropriate for a mobile multicultural population, involving outreach programs, community health workers, patient navigation systems, evening hours, and low-literacy health education.

Research related to the mobile poor is complicated by the very fact of their mobility. A study of the long-term effects of health care interventions for patients who are easily lost to follow-up is nearly impossible. During several years of work with the Bureau of Primary Health Care Health Disparities Collaborative, however, M/CHC providers working with migrant and homeless patients were able to achieve short-term outcomes (average HbA1C in diabetics and blood pressure control in hypertensives) for their chronic illness patients comparable to those achieved by their colleagues working with more geographically stable poor populations (unpublished data available at www.hdnr.org).

Most M/CHCs do not have abundant time or resources to perform research studies or test creative interventions. They therefore depend on the support of several dedicated national organizations that have focused their efforts over the past five decades on improving the health status of the mobile poor and their access to health care services. HRSA currently helps to fund Farmworker Justice[9] (Washington, D.C.), Health Care for the Homeless Clinicians' Network[10] (Nashville, Tenn.), Health Outreach Partners[11] (Oakland, Calif.), Migrant Clinicians Network[12] (Austin, Tex.), Migrant Health Promotion[13] (Weslaco, Tex./Saline, Mich.), National Association of Community Health Centers[14] (Washington, D.C.), and the National Center for Farmworker Health[15] (Buda, Tex.). They are assisted by countless local and regional organizations that advocate for migrant health care services. This network provides technical assistance, research studies, and educational resources in various forms including websites, conferences, print materials, and on-site technical assistance to health centers and providers who provide the direct primary care for the mobile poor. These organizations also provide a forum for an advocacy voice to local, regional, and national policymakers and employers on behalf of the mobile poor.

Current Challenges and Barriers for Health Care for the Mobile Poor

Unfortunately M/CHCs are only able to provide care for a small proportion of the total mobile poor population (it is estimated that less than 20% of farmworkers are served). The remainder has no access to health care services at all or seeks episodic care at free clinics, health department clinics, or local emergency rooms that often are not prepared to provide the scope and quality of services so badly needed by the mobile poor (e.g., transportation, interpretation, financial assistance, preventive services, as well as clinical care).

The mobile poor are today still faced with many of the barriers to the United States health care system that they encountered 50 years ago. Migrant workers struggle with problems of health care access similar to those of many other underserved populations, with the additional burden of having to search for new care options as they move. In addition, the desire by some to avoid contact with governmental agencies makes the access to health care even more complicated. Their mobility results in poor continuity of care, as they are often unable to complete medical treatments, keep track of medical records, and obtain routine or preventive care. Mobility is one of the larger barriers to continuity of care, and simultaneously increases the need for care.

Unfamiliarity with local health resources, inability to communicate in the local language, and ineligibility for publicly or privately funded health services are additional barriers to care. Health status is also affected by environmental and occupational exposure to hazardous chemicals, dangerous and repetitive work activities, and unsanitary housing and working conditions.[16] Most low-wage jobs do not provide sick leave or other benefits such as health insurance or workers' compensation.[17] Only 13 states require employers to provide workers' compensation coverage to migrant and seasonal agricultural workers to the same extent as other workers.

For migrant workers who are undocumented, legal status intersects with health status. The combination of growing socioeconomic problems in sending countries, economic policies such as NAFTA (the North Atlantic Free Trade Agreement) and a demand for low-skilled, low-wage workers in the United States, has intensified migratory pressures. Foreign-born workers have access to few legal means of entry to the United States, but the need for economic survival drives migrant laborers from their homes to search for work in this country. Many risk their lives to enter the U.S. There were over 5,000 border crossing deaths reported along the U.S.-Mexico border between 1993 and 2009, underscoring the extreme risks migrants take in order to just work.[18–20] Fear of deportation due to their legal status places farmworkers in a precarious employment situation where they are more likely to endure unfair labor practices and unsafe workplaces.[21–23] Numerous stories of the ill-treatment of migrant workers have been told.[24] Some employers may prefer migrant or even undocumented workers, whom they may see as willing to do more work for less pay and having little or no recourse to the law. Such pressures make workers reluctant to miss work and afraid of losing their jobs if they take time off to get medical care[25] and create a work force less likely to report workplace safety and wage violations, less likely to have access to training and protective equipment, and less likely to seek medical attention.[21,26–30]

Migration is highly stressful, as the facts recounted here suggest. In addition, migrant workers are often separated from their families, traveling on their own with no support. The family at home may be reliant on them to remit part of their income. Little is known about stress on the individual migrant especially in the home country setting. What part this may play in the development of health problems in migrants is unknown, though it is well recognized that rates of tuberculosis increase in stressed populations, such as in times of war.[31]

What happens when there are so many barriers to health care? Providers find that individuals present with advanced health care problems, the ultimate cost of treatment is higher, the outcomes of treatment are poorer; and morbidity and mortality rates are higher. Clinicians attempting to serve this population experience a parallel set of stresses, finding themselves in the midst of tension between overwhelming disparities and what they know is just. They are called upon to go the extra mile to develop understanding, trust and resources for patients who come to them with complex needs.

Future of Health Care for the Mobile Poor

The migrant poor are indispensable to the United States economy. For this reason as well as more fundamental reasons concerning human rights, health and health care opportunities for the migrant poor must improve. Means of providing quality health care services to the mobile poor have been proposed and advocated over many years. Some of them reflect the broken status of our health care system and others are symptomatic of deeper ills in our society. The most crucial interventions are:

1. Affordable health insurance for all.
2. Access to culturally and linguistically competent and high-quality primary health care services regardless of ability to pay or immigration status.
3. Realistic, comprehensive immigration reform that would recognize the need for millions of low wage, low skill workers with legal status to work in the United States. Such a policy change would protect the migrant poor by ensuring the basic human rights of adequate pay, safe working conditions, access to affordable health care, and coverage by workers' compensation.
4. Increased numbers of culturally and linguistically competent primary health care providers in all areas (primary care, dental, behavioral health).
5. Continuity of care and tracking for the mobile poor with the use of new technologies (cell phones, electronic health records, Internet, virtual case management) to ensure follow-up of abnormal tests and continuity of treatment regimens for mobile patients.
6. Education of the general public regarding the economic and cultural importance of this vital workforce to eliminate the current pervasive anti-immigrant sentiment in the United States.
7. Advocacy on local, state and national levels with policymakers to influence legislation relevant to health care services, worker protection standards, and other rights of migrant workers.

To date, there has been neither a consistent political will nor the appropriate public outcry to rectify the societal injustices borne by the migrant poor. We believe that those of us who are providers of health care for the nation's poor and underserved must advocate on behalf of migrant workers. Many frontline clinicians feel overwhelmed and uncertain about how to address the more profound problems raised by injustices in our health care system. At the same time, these clinicians can be powerful and credible advocates for justice on behalf of the patients they serve. It is important to recall a time when there was respect and support among political leaders for migrant workers—in 1968 Presidential candidate Robert Kennedy went to Delano, California, to break bread with Cesar Chavez at the end of his fast in protest of maltreatment of migrant farmworkers. Chavez in turn responded by committing the United Farmworkers Organizing Committee to campaign for Kennedy in the California primary. Their voter registration efforts provided Kennedy's margin of victory in California. We must continue to educate the public and our policymakers on the value that these hard-working, honorable individuals add to our economy and society.

Those of us who are privileged to interact with migrant patients during a time of need, when they may be at their most vulnerable and fearful, can stand as the example of how they should be treated by society. We can indeed be a force for justice for the health care of the mobile poor.

Notes

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