A Case Study of the Accessibility of Healthcare for Migrant Farmworkers

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This case study explores healthcare accessibility in reference to equality and vulnerability as it pertains to the Mexican farmworker community in West Volusia County, Florida. Surveys were orally conducted in Spanish among persons living in governmental and non-governmental housing to test an array of potential vulnerabilities. Survey results revealed that vulnerabilities such as socioeconomic position, lack of English proficiency, and legal status negatively affect accessibility to healthcare. The study also found that Medicaid services are insufficient given the negative correlation between Medicaid accessibility and vulnerability. In addition to statistical analysis this study also reveals the need for further research in the controversial arena of indigent immigrant healthcare.

María Lopez is a thirty-nine year old farmworker who lives in Seville, Florida. Her home is tidy and quaint and like all of the other apartments in Seville, after five o’clock there is an aroma of Mexican cuisine. Her five year old son sits on the couch and explains to a Farmworker Association volunteer, in English, how to play with his toy, while María Lopez eagerly begins to tell her story. Sra. Lopez admits that she has received medical services in the past year for her children and husband who needed emergency treatment. She utilized services from both the local clinic in Pierson and the emergency room in the Deland Hospital. However, her ability to pay for the treatment is limited due to their loss of Medicaid in the past year. She explains that the cost of treatment now is very high and it affects their decision to obtain medical care. The Lopez family meets all of the requirements of Medicaid. However, the person who helped them fill out their paperwork no longer works in the area and they were unable to complete the application process this year. Sra. Lopez said that she was satisfied with the healthcare she received when she had Medicaid but without it her family is unable to pay the high medical bills. The Lopez family appeared healthy but Maria’s weathered hands from years of agricultural labor may be harboring internal problems that are not yet visible, and small children are always susceptible to sickness. After leaving Sra. Lopez’s house, the only thing on my mind was that her family could not afford to get sick and her happy, healthy, intelligent five year old son may fall victim
Healthcare is a public policy problem. Millions of individuals in the United States do not have health insurance and cannot afford healthcare. Immigrants and minorities have more obstacles to overcome than white, U.S.-born citizens, making medical treatment even more difficult to obtain. Due to the complicated laws and the application process that shape Medicaid, individuals like Sra. Lopez are unable to complete the application process and millions of others are not even qualified to apply. There is little doubt that programs such as Medicaid provide a way for individuals to access medical treatment; however there is a question of equality as vulnerabilities hinder some people from accessing these services. The question is, are immigrants and minorities, specifically Mexican farmworkers like Sra. Lopez, able to access medical treatment when it is needed? This question is not as easy as it first appears. The question is less about the actual treatment that individuals receive and more about the policies that directly affect their decision and ability to receive care. If Sra. Lopez is unable to complete the application for Medicaid, her family is unable to get the medical treatment that the government acknowledges they are entitled to. There are other farmworkers who are in the same or worse socio-economic situation as Sra. Lopez and do not qualify for programs like Medicaid because they do not have dependent children, or have not lived in Florida for five years. All of the procedures and rules are pieces of an intricate policy puzzle that must fit together properly in order to be effective. Unfortunately many people are not equipped to put the pieces where they belong and the policy makers have not altered the puzzle to accommodate these individuals.

There are costs and implications to the policies that are created. Public policy programs enrich the lives of those who are disadvantaged or have fewer opportunities. What happens when these programs are created and do not cover some of the least advantaged members of the community? If it is their health at stake, where do they go when they are sick and who pays for their treatment? Whether it is in a long line in the emergency room or higher insurance rates and medical bills, someone will pay the costs. Can we, as a community, afford not to require that there be a more encompassing measure of equality in the public programs and policies created to allow access into the healthcare system?

**Review of the Literature**

Literature described in this review is discussed to provide the context necessary to understand the complex social and political aspects of the healthcare system. The following literature suggests that immigrant minorities are more vulnerable within the healthcare framework than the U.S.-born population. Two recent studies, one by Kathryn Pitken Derose, José J. Escarce, and Nicole Lurie (2007) and another done by Robert J. Blendon et al. (2007), outline the vulnerabilities that pertain to immigrants and how they vary among immigrant populations. In addition to literature on immigrant vulnerabilities there is also research supporting the lack of social cooperation necessary to improve indigent healthcare policy. The literature discussed below thus provides the evidence necessary to determine the importance and necessity of further research on immigrants and their interaction with the United States healthcare system.

Vulnerabilities, for the purpose of this paper, refer to those barriers that prevent immigrants from receiving medical services, thus making them more susceptible to poor health. In 2007, Derose, Escarce and Lurie took the approach of exploring the various sources of vulnerability that face immigrants in the United States. Sources of vulnerability included socioeconomic background, immigration status, and limited English proficiency (Derose, Escarce and Lurie 2007, 1259-1262). In addition to the study done by Derose, Escarce and Lurie, later research done by Blendon et al. (2007, 1441) found that disparities in health exist not only between minorities and the Caucasian population but also among minority subgroups. Blendon et al. (2007) explored the variance of vulnerabilities within four Hispanic subgroups (Puerto Ricans, Mexican, Cubans and Central/South Americans) and concluded that although similarities exist, the subgroups are not homogenous and must be studied individually. With the literature from Derose et al. and Blendon et al., the vulnerabilities that exist and the extent to which they vary among Hispanic subgroups are evident.

To understand how the vulnerabilities outlined above may hinder immigrants from receiving healthcare, the socioeconomic background, immigration status and limited English proficiency must be discussed in greater detail. The socioeconomic background of

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1 The illustration provided is a true story of a farmworker who lives in Seville, Florida. The information was provided while conducting surveys in Seville on the 29th of October 2007.
immigrants varies; and those of Mexican and Central American descent have the lowest socioeconomic status and are twice as likely to live below the poverty line than U.S.-born citizens (Derose, Escare and Lurie 2007, 1259). Mexican and Central/South Americans are also less likely to receive medical treatment when compared to other Hispanic subgroups (Blendon et al. 2007, 1441). Central/South Americans were more likely to say that they felt discriminated against due to their inability to pay for services than Mexican, Puerto Rican and Cuban immigrants (Blendon et al. 2007, 1443). The lower socioeconomic status of immigrants is therefore a vulnerability that threatens the rate of utilization and level of satisfaction of medical services.

Although the socioeconomic background of immigrant minorities can be challenging, U.S.-born individuals often face similar circumstances. The immigration status of foreign born individuals, however, is a vulnerability unique to immigrant minorities. Sixty-five percent of undocumented immigrants lack health insurance compared to thirty-two percent of permanent residents. Even though they are citizens, children born in the United States to non-citizen or naturalized parents are also less likely to obtain health insurance (Derose, Escare and Lurie 2007, 1260). Although immigration status impacts all foreign born residents, it may have a greater impact on those from Mexico and Central/South America, as their rate of medical utilization is far lower than Cuban and Puerto Rican immigrants (Blendon et al. 2007, 1441). Thus, the immigration status of Hispanic minorities is a vulnerability that potentially reduces the rate of medical utilization and prevents individuals from acquiring health insurance.

Beyond financial barriers and legal status, individuals with limited English proficiency are also less likely to have health insurance and utilize medical services. The limited English proficiency of immigrants results in less preventive care and fewer physician visits. According to Derose, Escare and Lurie (2007, 1261-1262), those with limited English proficiency also report lower levels of satisfaction with the healthcare they receive and have a lower understanding of their medical condition. When receiving medical services, one in four Puerto Ricans and Central/South Americans felt they received poor-quality treatment because of how they spoke English. However, Mexican, Cuban, Puerto Rican and Central/South Americans were all significantly more likely than whites to report discrimination due to their level of English proficiency when attaining medical treatment (Blendon et al. 2007, 1443). Thus, English proficiency, like the socioeconomic background and legal status of immigrants, is a vulnerability that reduces the accessibility and satisfaction of medical services. Previous studies provide evidence that there are a number of vulnerabilities that vary across cultures, hindering immigrants’ ability to obtain healthcare.

In addition to the evidence of existing vulnerability is the importance of social cooperation, which is highlighted by the success and failure of local initiatives. Communities with large migrant populations have taken initiatives at the local level to culturally accommodate individuals and circumvent the vulnerabilities that prevent immigrants from seeking medical treatment. Efforts, such as the following in Alameda County, California, reveal a lack of social cooperation that hinders the political success of healthcare policy. In order to expand the access of healthcare to immigrants and individuals beneath the poverty line, Alameda County took the initiative to create a more encompassing system. A five year pilot program called Alliance Family Care was created in 2000 to treat uninsured residents of Alameda County who were ineligible for public programs such as Medicaid. Fifty-four percent of the uninsured workers in Alameda County were Hispanic immigrants (Ponce, Nordlyke and Hirota 2005, 45-46). In a study done by Sherry Hirota and colleagues (2006), the successes of the five year pilot program were examined as were the reasons for its failure after the five years. In 2002 over 7,500 people were enrolled into the program and 3,000 were placed on a waiting list (Hirota et al. 2006, 88). Vulnerabilities were taken into consideration with affordable co-payments, quick and easy enrollment and eligibility requirements that did not include citizenship. Thus, the program was successful in enrolling uninsured individuals and increasing the overall use of preventative care. However, after five years the program ended due to inadequate funding. The program could not survive without federal and state government support. Hirota et al. (2006, 90-92) proposed that financial resources used to fund medical care would be more efficient if resources were consolidated at the state or federal level. The conclusions were based on the failure of the Alliance Family Care pilot program in California and the cost-effectiveness of federally funded community health centers.

The local initiative in Alameda County and the financial research done by Hirota et al. provide the political context of this
subject. There are medical needs, costs and ramifications that flood the political arena at the federal, state and local level. Alameda County is a case study of the difficulties faced at the local level. This California County knew the cultural and financial difficulties within the community and took them into consideration to create a program that expanded the access to medical services. Although Alameda County was successful in expanding medical coverage to uninsured people, without federal or state financial assistance the success of the program could not continue. Healthcare funding is therefore complicated and often intertwined at the federal, state and local level. With federal funding for some communities and local initiatives in others, everyone is working to improve the health of the community. However, everyone is taking different routes and until there is a certain level of social cooperation among communities, states and the federal government, political actors will rarely find themselves successfully merging into the same political lanes. Therefore, without social cooperation, the resources committed to expanding the access of healthcare will continually fail to reach the growing number of uninsured.

How does the literature address and direct our research with the Mexican farmworker community? First, because Mexican farmworkers are an immigrant minority, we can assume that they are going to have specific socioeconomic, legal and cultural vulnerabilities that limit their access to healthcare. Second, we recognize that our research is only applicable to Mexican farmworkers, not to the entire Hispanic community, due to cultural differences among Hispanic subgroups. Lastly, we know that although there is a lack of social cooperation between the federal, state and local entities, local awareness and leadership can be powerful in initiating communal collaboration to increase the accessibility of healthcare. Thus, the vulnerabilities unique to the Mexican farmworkers must be discovered and brought to the attention of the community to begin changing the economic, cultural, and political barriers which exist.

**Context**

In addition to the theories developed in the literature review, it is also necessary to outline specific concepts about the Mexican farmworker community and indigent health to further understand the obstacles facing the Mexican farmworkers and the legal framework in which they live.

*The Farmworking Community in the United States*

The terminology on this topic can be inclusive and exclusive. It is important to understand what population the literature is referring to and the different ways it can be referred to. Important terms to distinguish include immigrant, migrant worker and farmworker. Immigrants are people who were born in one country and settled in another. All foreign-born persons living in the United States are immigrants, and each of the following constitute one third of the immigrant population: naturalized citizens, legal permanent citizens and undocumented immigrants. A migrant worker is defined by The Migrant and Seasonal Agricultural Worker Protection Act (U.S. Department of Agriculture 2002) as an individual with seasonal or temporary agricultural employment, who is absent overnight from his/her permanent residence. A farmworker refers to an individual who is employed agriculturally. The three terms can overlap and be used to refer to the same group of people. For example, farmworkers in the United States are usually immigrants that migrate seasonally to find work. However, an immigrant is not necessarily a farmworker or a migrant worker and a farmworker is not necessarily migratory (Derose, Escare and Lurie 2007, 1255-1259). For our purposes, and in reference to the literature, migrant workers, farmworkers and immigrants will refer to the foreign-born predominantly Mexican community, both documented and undocumented, if not specified, within the United States.

There are over thirty-six million immigrants in the United States and twelve million are undocumented immigrants. Eighty-one percent of the undocumented are from a Latin American country. An overwhelming majority of Latin American immigrants are farmworkers. Eighty-one percent of farmworkers are foreign-born and seventy-seven percent of them are born in Mexico (Derose, Escare and Lurie 2007, 1258-1259). In 2000, fifty-six percent of farmworkers were migratory. The majority of migratory farmworkers temporarily resides in and migrates among California, Texas, Florida, Georgia, Oregon, and Washington (Rosenbaum and Shin 2005). The average migrant worker only has a sixth grade level of education, and a 2000 survey reported that 87% of farmworkers spoke little to no English (Rosenbaum and Shin 2005; Triplett 2004). Migrant farmworkers not only have an extremely low level of
matches dollar-for-dollar what each state government spends on the program (U.S. Department of Health and Human Services 2005). The federal government establishes the basic guidelines for Medicaid while each state adds their own rules and regulations for the program. In the state of Florida, families with dependent children from ages 6-19 that are one hundred percent below the federal poverty level are eligible for Medicaid (Florida Department of Children and Families 2007). A family of four, with children between 6-19 years of age, which made $19,350 or less, would be eligible for Medicaid after an assessment of other assets, such as saved money and vehicles.

Medicaid provides benefits to millions of people in the United States, however there are numerous barriers for migrant workers. Many farmworkers are not eligible because they are not disabled nor do they have dependent children. In addition, the 1996 Personal Responsibility and Work Opportunity Reconciliation Act prohibited legal immigrants from accessing Medicaid for the first five years of their residency in the United States. This law excludes a number of legal immigrants from receiving care (Rosenbaum and Shin 2005). Inaccessible site locations and limited English skills also prevent immigrants from completing the enrollment process. Federal law requires Medicaid programs to overcome language barriers. Interpreters, however, are not always available in all medical services, nor are they available during all operating hours (Derose, Escarce and Lurie 2007, 1261). The state-based structure of the Medicaid program makes it challenging for migrant workers who move between states to maintain their Medicaid eligibility. States are required to provide out-of-state coverage, but not all states honor an out-of-state Medicaid card for services outside of emergency care (Rosenbaum and Shin 2005). The immigration status of farmworkers poses another barrier preventing those who are treated in the emergency room from filing for Medicaid assistance for fear of deportation. Although Medicaid provides health benefits to millions of families who are impoverished, some of the most impoverished people (foreign-born farmworkers) remain uncovered.

There is a debate on whether immigrants, predominantly Hispanic, should be provided public benefits such as healthcare. Legitimate questions are being asked. Should we provide services to immigrants who are documented, temporary, or undocumented when native-born citizens are suffering? What about the low-income citizens and the tens of millions of Americans without health

Healthcare

Medicaid is a federal entitlement program available to families with limited income and dependent children, disabled persons or individuals over the age of sixty five. Medicaid provides healthcare to 35.1% of the people in the United States. The federal government and each state share the cost of Medicaid; the federal government

education but they also are at a lower financial level than the average citizen (Triplett 2004, 836). According to the National Agricultural Workers Survey, the median annual income for migrant workers was $6,250 compared to $42,000 for U.S. workers (Rosenbaum and Shin 2005). The extreme poverty and low educational level of migrant families forces both parents and children to work in the fields. The educational and financial status of migrant workers results in a unique community of individuals with rigorous environmental and working conditions.

Migrant workers are exposed to harsh, unsanitary living conditions and dangerous working environments. The nature of their work presents unique medical problems within the farmworker communities. Many farmworkers are exposed to dangerous pesticides and spend hours hunched over picking fruits or vegetables. Pesticide exposure often causes lung and respiratory problems, along with dermatitis and skin discoloration. Many migrant workers also develop chronic back pain and arthritis (Farmworker Association of Florida 2006, 10). The living conditions within the communities also pose potential health problems. Their housing quarters are often tight, with many people occupying a small living area and entire communities crammed into a small designated area. As a result of the congested living quarters, many farmworker communities encounter a Tuberculosis outbreak. Between the nature of agricultural work and personal living environment, farmworker communities suffer from a range of health problems and are at a greater risk for exposure to disease.

The educational and economic status combined with the work environment of predominantly Mexican-born farmworkers creates an unhealthy population of people unequipped educationally or financially to effectively care for themselves and seek the necessary treatment they need. The structure and legal framework of the healthcare system only complicates the already gristy health environment of farmworkers.
insurance? Do foreign-born individuals have a right to publicly funded services? These questions have not been answered directly but precedent has determined that laws excluding immigrants from public benefits are unconstitutional, and the literature suggests that the costs of not providing healthcare are higher than granting the Hispanic immigrant population access to treatment.

Some states, including California and Texas, have implemented laws to exclude immigrants from public health and education. In 1994, California passed Proposition 187 which denied all immigrants public health until they could prove their legal right to reside in the United States. Those that were undocumented were given sixty days to prove legal residency or they were deported. Proposition 187 was taken to court and ruled unconstitutional (American Patrol Report 2007). A similar event happened in Texas when the state changed its education laws to exclude undocumented immigrants. In 1982, Plyler v. Doe was taken to the Supreme Court. In a five to four decision the Texas laws were considered unconstitutional, violating the Fourteenth Amendment (Brennan 1982). The failure of Proposition 187 and the outcome of Plyler v. Doe offer precedent to one side of the debate. Laws that exclude undocumented immigrants from public benefits are therefore unconstitutional and unsuccessful. Literature also suggests that there are more than constitutional consequences to denying public programs to immigrants.

The costs of providing uncompensated care have ramifications for state and local governments, counties, hospitals and taxpayers. Illegal and legal Hispanic immigrants are two and half times more likely to be uninsured than native-born citizens. Individuals who are uninsured utilize hospital services for care because United States law requires all hospitals to treat and stabilize every person seeking emergency care. However, emergency room care is the most expensive form of medical care. In 2001, public funds paid eighty-five percent of the $38 billion deficit due to uncompensated medical expenses of the uninsured. The programs created to reimburse hospitals for emergency care given to immigrants under the Illegal Immigrant Reform and Immigrant Responsibility Act of 1996 have not been funded (Green and Martin 2004, 227-229). Thus, if underinsured immigrants over-utilize emergency room care external costs are created that must be paid for at the local level.

The use of the emergency room as a primary care provider creates a plethora of obvious financial costs, but there are also distinct social costs. One social cost that directly affects most people is the longer lines in the emergency rooms. At Cochise’s Cooper Queen Community Hospital in Arizona there is a four to six hour wait in the ER (Green and Martin 2004, 230). Other social costs include serious public health problems due to unsanitary living conditions and unhealthy communities (Blendon et al. 2007, 1441). A 2006 community health survey done in Lake Apopka, Florida, reveals that over fifty percent of the farmworker community suffered from arthritis, allergies, and sinus and throat problems (Farmworker Association of Florida 2006). Tuberculosis is also a common threat to migrant workers who live in congested areas. By not providing more accessible care for immigrants we are potentially exposing ourselves to contagious diseases and promoting a growing unhealthy environment. The lack of preventive care and health insurance force immigrants to wait until their situation is unbearable before seeking medical treatment resulting in higher hospital bills. The external social costs of not providing healthcare are not only potentially hazardous to the health of the community, but they are intertwined with the financial costs.

The financial costs of not providing healthcare to immigrants are profound and have numerous consequences. Communities with large numbers of uninsured individuals reallocate money in order to pay for the uncompensated medical care. Money that could go to disease prevention or other hospital services is used to pay the hospital bills of the uninsured. The amount of money accumulated in hospital bills for the uninsured is astronomical and the consequences of these costs are endured by society. In 2002, the Texas Hospital Association found that Texas hospitals spent $393 million treating illegal immigrants. In Florida, Broward County collects $190 million in property taxes to compensate the $453 million lost in uncompensated hospital bills. From 1994 to 2004, sixty California emergency rooms closed due to bankruptcy. In 2003, forty-nine states implemented Medicaid restrictions while Colorado saved 2.7 million dollars by completely removing immigrants from their Medicaid program (Green and Martin 2004, 230-234). The financial costs of not providing health services to immigrants are high and must be paid for. Counties, hospitals and taxpayers are the ones left to pay the bills or face the consequences. The question of whether immigrants, legal or illegal, should be provided for is no longer the question, as it costs more financially and socially to deny immigrants access to care than to include them.
Methodology

To measure the vulnerabilities of the Mexican farmworker community in West Volusia County, Florida, surveys were designed to test the following four hypotheses:

1. If farmworkers have a low rate of medical utilization, it is due more to the cost of medical services than the lack of English proficiency.
2. If farmworkers do utilize medical services they will have a higher rate of utilization in the emergency room than in the local clinic or alternative forms of medical services.
3. Individuals who live in governmental housing will have a higher share of individuals who know what Medicaid is and utilize its services than those that live in non-governmental housing.
4. Individuals who live in governmental housing will have a higher rate of medical utilization and satisfaction with medical services than those that live in non-governmental housing.

These hypotheses were designed to measure the utilization and satisfaction of the farmworker community with their healthcare system. In accordance with the literature, the hypotheses take into account the number of vulnerabilities that could be a factor. However, it is hypothesized that although a number of vulnerabilities exist, cost is the most critical factor affecting an individual’s decision to obtain medical treatment. If the first hypothesis is true, it is logically hypothesized that farmworkers would utilize the ER, which by law has to treat people in spite of their ability to pay. The last two hypotheses were created after the actual survey process was started due to new logistical information that was unknown at the time of design. In Pierson, Florida, there are a number of different housing situations, with both governmental and non-governmental housing. Those that live in governmental housing are required to have a certain amount of documentation to live and work in the United States. With this new detail, other independent variables were created and a comparative aspect was added to the analysis. The comparison between governmental and non-governmental housing will hopefully provide deeper insight into how some government benefits lead to the knowledge and utilization of others, such as Medicaid. In this case, it is hypothesized that individuals living in the governmental housing will know about Medicaid and utilize these services more than those that live in non-governmental housing. Therefore, it is also hypothesized that those who live in governmental housing and who may possibly have Medicaid will seek more medical services than those who live in non-governmental housing.

Research Design

Surveys and interviews appeared to be the logical approach in order to gain a true understanding of the vulnerabilities that affect the accessibility of healthcare within the farmworker community. The initial idea was to create in-depth surveys that analyzed as many barriers as possible including immigration status, education and economic stability. Interviews were to be supplemental, providing additional details and personal stories to enrich the research with real examples. Interviews were not done within the farmworker community. It was difficult to arrange interviews with members in the community while also conducting oral surveys. The initial design was a noble venture but unfortunately the actual approach had to be adjusted due to time constraints, levels of trust and the education level of the participants.

In order to develop effective surveys and gain access into the farmworker community, a member of the Florida Farmworker Association was contacted. Lariza Garzon, a Stetson University alumna and survey coordinator for the Florida Farmworker Association, became the expert on, and gateway into, the farmworker community in West Volusia County. When the initial plan was discussed with Lariza, immediate changes had to be made. Lariza suggested that the surveys be limited to one page to keep the participants engaged and so as not to discourage future cooperation. The surveys went through three drafts and the questions were narrowed to one page and categorized into two sections. The first section gathered general profile information such as sex, age and occupation. The second section asked questions pertaining to the utilization and satisfaction of medical treatment received and Medicaid. The immigration status of participants was also an important question to ask in order to understand the range of possible vulnerabilities. Unfortunately, this question could not be directly asked due to levels of trust between the participants and myself and the real fear of deportation for a number of individuals. However,
this question was not forgotten but rather referred to indirectly. It is assumed that those that live in governmental housing or receive Medicaid services are properly documented. In the case of children that receive Medicaid, it is assumed that they were born in the United States and are citizens.

Another fact that was not taken into account was that the majority of the population in Pierson is illiterate. Therefore, all of the surveys done by the Farmworker Association are done orally. As a result, rather than a traditional written survey which was part of the initial plan, the surveys done for this project were conducted orally. Each survey participant was asked a series of questions pertaining to age, satisfaction with medical services and Medicaid status. The oral responses were recorded on the written survey I designed.\(^2\) Due to the time constraints of this project it was extremely helpful to have a short survey that allowed me to move more rapidly and reach more people. After many revisions to the initial design of the surveys it was decided that all of the surveys would be conducted orally in Spanish, in three different locations.

To gather the most random sample possible, oral surveys were conducted in Seville, the Community Plaza and in housing areas provided by growers. The people surveyed in Seville lived in housing subsidized by the government; the governmentally subsidized apartment complex was called New Hope Villas. In order for farmworkers to live in the New Hope Villas they had to have both their green card and a social security card. At the center of the apartment complex in Seville there is a community center with an office, a daycare service and a playground. In Seville, door-to-door surveys were conducted in the afternoon over a span of two days. These surveys were done with the Farmworker Association which was also conducting surveys in the area. All the participants of the survey received cereal and those with children received school supplies. The cereal and school supplies were donated by churches and provided by the Farmworker Association. Every person that was home and answered the door participated in the survey.

Oral surveys were also conducted in the Community Plaza in Pierson. Inside the Community Plaza there is a bank. On every second Friday of the month farmworkers in Pierson cash their checks at the Plaza. Inside the door of the Plaza a table was set up for surveys to be conducted. Cereal and school supplies were visible to the people in line cashing their checks and available for participants in the surveys. The cereal and school supplies were a vital incentive in the success of the surveys obtained in the Plaza. The people in the Plaza, however, were less willing to participate in the surveys because they were less comfortable. Some of the questions were personal and the survey area was in the open, not in a private home setting like the participants in Seville. When the surveys were conducted it was assumed that the majority of participants would be male. The majority of survey participants at the Plaza, however, were female with children. A lot of the participants inquired about the school supplies displayed and eagerly agreed to participate in the survey in exchange for the free items. Thus, incentives were necessary and vital to the rate of participation in the Plaza.

The third wave of oral surveys was done in the housing areas provided by growers to farmworkers. The housing conditions were extremely different from the community environment in Seville or the clean tiled floors of the Plaza. For safety reasons the surveys were conducted with the supervision of Don Marcos, the head of the Community Plaza. The surveys were done similarly to those in Seville. However, instead of surveying families that lived in individual apartments, the families interviewed lived in cement houses that were all connected. There was no pavement or designated parking lots, only one dirt road with no outlet. There was also no playground or daycare center, only piles of toys and litter in the front yards. Due to the limited time constraints and the inability to coordinate schedules with the Farmworker Association, this population was under-surveyed. Only seven surveys were gathered from those that live in grower housing. To compensate for the lack of information about this group, the results of these surveys were combined with the survey results from the Plaza. Thus, the results are presented in terms of governmental housing and nongovernmental/unknown housing. It is unfortunate that the number of surveys conducted within grower housing were insufficient to be displayed separately and the importance of having these surveys is addressed in the ideas for further research.

Discussion and Findings for the Farmworker Community in West Volusia County

Over two months, forty-three surveys were administered. In order to analyze the data it was entered into Microcase, a statistical analysis
The results of the survey were used to create a database. Cross tabulations were performed with Microcase to analyze the significance of the variables and assess the validity of the hypotheses. The utilization and satisfaction are analyzed first in reference to the total survey population and then broken down by residency to address both hypotheses one and four. Approximately sixty-three percent of the forty-three farmworkers surveyed utilized medical services in the last year. In order to determine the level of satisfaction, participants were asked to what degree they were satisfied with the medical treatment they received. Overall, fifty-three percent of those surveyed were satisfied. Eighteen percent were very satisfied and only 2.3 percent were very unsatisfied. However, more than 11 percent did not know their level of satisfaction because they had never received medical care in the United States.

In order to address the first and fourth hypotheses, the utilization and satisfaction of farmworkers had to be broken down by their place of residence. The number of participants in governmental housing that received medical services was only slightly higher than those that did not live in governmental housing. Surprisingly, sixty-one percent of those that did not live in governmental housing received medical services in the last year. However, it must be noted that the exact residence of the majority of the participants in this category was unknown. Therefore, some of them may live in governmental housing. It is also important to recognize that the percent of utilization is higher for those that live in Seville but the number of participants is lower. According to the results of this survey farmworkers in Pierson will utilize medical services at a similar rate no matter where they live.

Figures 1 and 2 represent the satisfaction level of those living in both governmental housing and non-governmental housing. The first represents the satisfaction of those living in governmental housing in Seville. Fifty-nine percent of the participants were satisfied and 29 percent were very satisfied. None of the participants interviewed in the governmental housing were very unsatisfied.

Unlike the breakdown of utilization, the results for those that lived in non-governmental or unknown housing were different (see Figure 2). Only 50 percent of these participants were satisfied with the medical services they received and 11.5 percent were very satisfied. In contrast to those living in governmental housing, 4 percent of nongovernmental/unknown residents were very unsatisfied and 19 percent did not know their level of satisfaction.
The rate of utilization and levels of satisfaction discovered with the survey results do not support the first hypothesis. The farmworkers in both governmental and non-governmental housing have somewhat high levels of utilization, with over fifty percent of participants utilizing medical services. Therefore, the first hypothesis which states that if farmworkers have a low rate of medical utilization it is due to the cost of medical services is not applicable since there is not a low level of utilization. However, the cost of medical services versus English proficiency, travel distance, and fear of losing one’s job may be important in understanding why 37 percent of the participants are not utilizing medical services. The cost may also explain why some are unsatisfied with the services they receive.

Figures 3 and 4 break down the reasons that affect the decision of farmworkers to receive medical services. The charts do not represent percentages of individuals, but the number of times each factor was chosen, as participants could choose more than one answer.\(^3\) There are noticeable differences between those that live in governmental housing, represented in Figure 3, and those that live in nongovernmental or unknown housing, shown in Figure 4. Cost appears to be the dominant factor in the decision of people to obtain medical services, as predicted in the first hypothesis. However, in nongovernmental/unknown housing, lack of English proficiency is the more dominant factor affecting the decision to obtain medical treatment.

These results are a depiction of the answers given by survey participants, however there is reason to question the accuracy of these results. The individuals interviewed in the Community Plaza were interviewed in a public area, where others could hear their responses, in contrast to those interviewed in the privacy of their own home. Due to this environmental factor, some details may have been left out and although never implied by any of the individuals interviewed, the element of cost may not have been fully addressed. Although the results illustrate the expressed fears of farmworkers, the results may be skewed; therefore they are read with caution and not used for anything more than an interesting comparison and a basis for future research.\(^4\)

\(^3\)See Appendix, question number three.
\(^4\)The question in the survey is considered by the researcher to be very personal as it asks each individual to access the fears that may affect the decision to not receive medical treatment. Therefore, the level of comfort that the individual has when answering this question is very important. Those interviewed in public may not have been comfortable answering such a personal question in a public space. Thus, the accuracy of the results is called into question.
would have higher satisfaction and utilization of medical services yielded better results. Individuals that live in governmental housing are more satisfied; however, these results are not significant. There is no relationship between residency and utilization or residency and satisfaction. When cross-tabulations are done the significance levels are .433 and .434 and are therefore not significant in either case. However, the satisfaction of medical services received by farmworkers does differ between individuals and the reason for this variance needs more attention and should be explored in future research.

Where Medical Services Were Utilized

The second hypothesis, unlike the first and fourth, is better supported by the results of the survey. It was predicted in the second hypothesis that farmworkers would utilize the emergency room more than other medical venues. According to the survey results, the farmworkers in Pierson did utilize the emergency room more than the local clinic or alternative forms of medical services. Figure 5 breaks down the utilization of farmworkers. Individuals were allowed to respond to all of the answers that were applicable to them, thus there is a category for individuals who utilized both the ER and the local clinic in the past year. In comparing only the results of people that went strictly to the ER and those that only went to the clinic, there is evidence that the ER was utilized more than the clinic. However, it is important to remember when analyzing the results that the percentage of people that went to the ER is higher than 18.6 percent because there is another 18.6 percent of individuals that went to the ER in the combined category of individuals that went to the clinic and the ER. Thus, the second hypothesis, that farmworkers would utilize the ER more than other medical services, is supported by the survey results as the participants utilized the ER more than they utilized the local clinic or alternative medical options.

These results are very important because as mentioned in the review of the literature, the ER is the most expensive form of medical services available and they are required by law to stabilize every person despite nationality, race or legal status. Therefore, according to the surveys administered, the farmworkers in Pierson are utilizing the most expensive form of medical services and forty-six percent of them are not utilizing any services at all.

Figure 5: Place of Utilization

Medicaid Awareness

The third hypothesis states that there will be a larger share of individuals who knows what Medicaid is and utilizes its services in governmental housing areas compared to non-governmental housing areas. Two cross-tabulations were done to determine the significance of the independent variable, residence, on the dependent variables, knowledge of Medicaid and utilization of Medicaid. The first cross-tabulation showed no significance. Over eighty percent of participants in both governmental and non-governmental housing knew what Medicaid was. Thus, the results pertaining to the knowledge of existing Medicaid programs were surprising.

It was not predicted that a majority of farmworkers would have an understanding of what Medicaid is, due to the advantage of some already receiving governmental assistance by living in governmental housing. However, when the dependent variable is changed from knowledge to utilization of Medicaid, the results are not surprising. The second cross-tabulation with the dependent variable, utilization of Medicaid, yielded very different results with a significance level of .07. The .07 level of significance is very weak but the differences between the participants in Seville versus non-governmental/unknown housing are evident. Seventy percent of the participants that live in Seville have Medicaid compared to 35 percent of participants in non-governmental or unknown housing. The .07 significance level and the large difference between individuals that
live in Seville and those that live elsewhere suggests a relationship between the two variables. However, the weak significance level also suggests that residency may be an intervening variable. The real independent variable could be legal status, as those that live in Seville have to be documented to qualify and live in the governmental housing.

Conclusion

The results of the surveys conducted in Pierson have painted a new, more accurate picture of what is going on in the realm of healthcare in the farmworker community. A majority of farmworkers do utilize medical services in West Volusia County. Although this may be good news for the health of the community, there are still some serious problems. The vulnerabilities, such as socioeconomic status and lack of English proficiency as mentioned in the review of the literature, are affecting the healthcare accessibility of farmworkers in Pierson. These vulnerabilities are driving the fears that affect the decision of individuals to obtain treatment. The legal status of farmworkers, also mentioned in the literature review, is another issue within the community. Although legal status was measured indirectly with the independent variable of residency, levels of satisfaction and utilization of Medicaid still varied. Individuals living in governmental housing are more satisfied and have higher rates of Medicaid utilization. Thus, it appears that the vulnerabilities of socioeconomic background, lack of English proficiency, and legal status affect farmworkers in West Volusia County.

The vulnerabilities of farmworkers in Pierson are not the only problems discovered in this study. The results also supported the research found on Medicaid as the process and services of Medicaid provided within the community were insufficient and unsatisfactory. The community has done a good job alerting the public to programs that exist, as over 80 percent of those surveyed knew what Medicaid was. However, there is some discrepancy with the utilization of Medicaid as 34 percent of residents living in non-governmental housing do not have Medicaid. In West Volusia County, Medicaid is not reaching the most vulnerable and least advantaged members of society. When the least advantaged are not reached there are ramifications. One consequence is that individuals have the potential to become more vulnerable, but there are also political ramifications that raise prospective policy ideas.

When Medicaid is insufficient, ramifications spread from the least advantaged member of society to the rest of the community. If individuals are unable to pay for medical treatment an overutilization of the emergency room can occur. As discussed in the results, there is a high rate of utilization of emergency services within the farmworker community, thus suggesting an overutilization of the ER in West Volusia County. When the emergency room is overused as a place for preventative care there are long lines that United States citizens must wait in, and higher hospital bills that United States citizens must pay. If governmental programs such as Medicaid fail to reach the least advantaged in West Volusia County, there are serious problems that affect every citizen within the community, not just farmworkers.

The potential problems that result from not having accessible healthcare for farmworkers can be circumvented with new policy initiatives. If all of the rules and procedures are pieces of an intricate policy puzzle that must fit together properly in order to be effective, let us play with the pieces so the puzzle falls into place. For example, laws such as the 1996 Personal Responsibility and Work Opportunity and Reconciliation Act, which excludes documented immigrants from accessing Medicaid for the first five years of their residency in the United States, should be eradicated as they deny legal individuals the help they need to access treatment for five years. Another initiative that may simplify the Medicaid process is to require that there be a salaried bilingual intermediary in areas like Pierson to assist individuals in completing all of the paperwork. By only doing these two things a number of people, like Sra. Lopez, would be ensured the assistance they are entitled to. However, in order to reach the undocumented population new local initiatives will have to be made. West Volusia County has a high amount of tax dollars going to indigent health. Although the allocation of this money is not a focus in this study, the fact is there is money within the community designated to farmworkers. Thus, an initiative should be taken to arrange a program in the Pierson Medical Center to provide inexpensive preventive care to everyone, despite their legal status. The Pierson Medical Center is seen by the community as an expensive and therefore unattainable venue for treatment. The Pierson Medical Center was created to improve the health of the community but without some local initiatives only few will continue being served. If an effort was made to make preventive care more affordable, there would be a healthier, more satisfied community.
When such objectives are reached the pieces of the puzzle begin to fit together and function as a whole.

Unfortunately, the puzzle pieces at this time are not in their proper place and some pieces are missing entirely. Individuals like Sra. Lopez cannot complete the Medicaid paperwork and thirty-four percent of farmworkers in non-governmental housing cannot access Medicaid at all. To complete the puzzle, change must occur in healthcare policy for immigrant minorities. If change is not initiated because immigrants are more vulnerable or because we are concerned with the health of every person, then change should occur because the middle-class citizens of the United States primarily bear the public financial burden of immigrant minorities. The question now becomes: what can we as a community do to ensure equal access to medical care and how long can we wait to act?

There are a lot of opportunities for further research on this topic in West Volusia County. In order to have more accurate statistics, more surveys need to be done. It is essential that more surveys of individuals living in grower housing are done due to the low numbers represented in this analysis. The third question asked in the survey administered should be redesigned, as it is hypothetical and lacks depth. The third question asked the participants what would affect their decisions to obtain medical care if they were sick. This is a very important question as it alludes to a number of possible reasons that individuals may not seek medical treatment. However, because this question is hypothetical, it makes it difficult to test hypotheses. In order to make the question more valuable it should be reworded to collect factual information. For example, if the participant says he did not receive medical care in the last year, then he should be asked if one of the following affected his decision to obtain medical care. With this question reworded and more surveys done, especially in grower housing, the statistical information may change and be better solidified, providing more accurate insight.

Another area for further research would be the investigation of the emergency rooms and local clinics in West Volusia County. The number of people who have Medicaid and whether or not Medicaid is accepted by the medical provider should be investigated. The average waiting time in the ERs and the rate of farmworker utilization should also be determined. Interviews with medical personnel and statistics on the number of people who cannot pay their ER bills would also be vital information. The amount of money given to the Pierson Medical Clinic should also be examined closely to make sure tax dollars are being allocated appropriately in regards to indigent health. Research done within the medical environment would be critical in determining the extent of the social and economic costs to U.S. citizens. It would also be important in assisting policy makers formulate better healthcare policy for everyone.

Valuable insight will result with further research in the farmworker community at the local level and within the medical environment. This insight is critical in creating new policy and improving the status of health and ultimately the life of many individuals. Therefore, future research is not only essential to the creation of new policy initiatives, but it also has the potential to change lives. Great opportunities exist to make a difference at the local level and impact the future of healthcare policy.

Appendix: Sample Survey

Encuesta General

Edad:

Ocupación:

___ Trabajador agrícola
___ Construcción
___ Otro

¿Tiene familia en Florida? Sí ___ No ___

1. ¿Usted o alguien en su familia ha visitado el médico o ha recibido servicios médicos en los últimos 12 meses?
   - Sí ___ No ___

2. ¿Ha ido, usted o alguien de su familia, alguna de los siguientes lugares en los últimos 12 meses? Circule todo lo que sea pertinente.
   - la sala de urgencias (ER) ___
   - Una clínica local ___
   - Un miembro de su comunidad por tratamiento tradicional ___
   - Otro ___
   - Nada ___

3. ¿Si usted o un miembro de su familia estuvieran enfermos, cual de las siguientes razones afectaría su decisión obtener tratamiento médico? Circule todo lo que sea pertinente.
   - Miedo a que afectara su trabajo ___
   - Costo del tratamiento ___
   - Manejo del inglés ___
   - La distancia de su casa al médico/clinica/hospital ___
4. ¿Sabe que es Medicaid?
- Sí  
- No  
- No sé

5. ¿Tiene los servicios de Medicaid?
- Sí  
- No

6. ¿Ha vivido en Florida por lo menos cinco años?
- Sí  
- No

7. ¿Cómo satisfecho está usted con los servicios médicos que ha recibido?
- Muy satisfecho
- Satisfecho
- Descontento
- Muy discontento

References


