RURAL CALIFORNIA REPORT

CALIFORNIA INSTITUTE FOR RURAL STUDIES

Vol. 12, No. 1, Winter/Spring 2001

SPECIAL FARM WORKER HEALTH ISSUE

Mother with ill child from Earlimart, Calif. Bill Gillette

Binational Study Sounds Alarm on Worker Health

Survey Identifies Key Care Issues Among Migrant Populations

How often do California's immigrant farm workers see a doctor or dentist? According to a recent survey conducted by the California Institute for Rural Studies (CIRS), almost half (47 percent) had not visited a doctor and more than half (58 percent) had not seen a dentist in at least two years. Even more alarming were results that showed more than one-third of those with serious illnesses had not been receiving needed treatments. For example, one-sixth of the respondents reported suffering from diabetes, high blood pressure or vascular disease. More than one quarter (27 percent) of this group did not visit a doctor in two years.

These distressing figures indicate a need for renewed efforts to improve worker health services, but what is the best approach to take? To shed greater light on this problem and help policymakers and program managers develop effective strategies, CIRS examined both the patterns of farm worker health care as well as the factors influencing them.

The study, funded by The California Endowment and known as the Binational Health Survey (BHS), surveyed randomly

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An Unhealthy Bargain

Facing up to the Challenge of Farm Worker Health

Our capacity to produce far exceeds our ability to distribute well-being. Support for this assertion can be found in the simple fact that more than 7 million Californians have no form of health insurance—a Damocles sword that most of us would shudder to face.[1] The situation is even more grim with respect to California's farm workers.

CIRS's California Agricultural Worker Health Survey (conducted in 1999 with funding from The California Endowment) found that 75 percent of 968 workers interviewed had no health insurance whatsoever. But perhaps we should not be surprised, given the predominantly seasonal, part-time nature of the employment and the extremely competitive and cost-conscious pressures within this sector of the food system.[2]

Also significant was that 34 percent of the respondents indicated they were undocumented immigrants. While we can debate just how much this self-reported data under reports the true measure, it is clear that a high proportion of California farm workers are categorically ineligible for Medi-Cal or other forms of publicly supported health insurance.

Perhaps the most striking findings concern the frequency of visits to health care providers, particularly doctors, dentists and optometrists. Nearly 32 percent of men reported that they have never seen a doctor (among women the figure was 10 percent), while nearly 50 percent and 70 percent of all subjects reported having never visited a dentist or optometrist, respectively. These numbers again indicate

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RURAL CALIFORNIA *REPORT*
WINTER/SPRING 2001 VOLUME 12, NO. 1

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Rural California Report is a quarterly publication of the California Institute For Rural Studies (CIRS). For over 20 years CIRS has conducted research and outreach aimed at improving lives, conditions and economies of rural areas. The mission of CIRS is to work toward a society that is socially just, economically sustainable and ecologically balanced. To achieve this goal, we conduct policy research that takes an integrated approach to issues affecting rural communities, rural economies and rural environments.

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L E T T E R S

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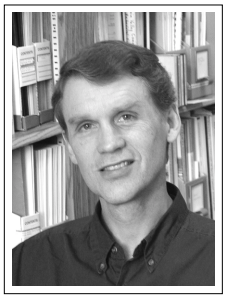
Director's Corner



As a relative newcomer to this state, I am always struck by its magnificent landscape, so punctuated by mountains and valleys that its scenic grandeur is always on display. While catching my breath after a recent climb up the east ridge of the Vaca Mountains near the northern Central Valley, I marveled at what nature had wrought. To the north snaked the Lake Berryessa Reservoir, to the east lay the wide Sacramento basin and the snow-capped Sierra massif. It was a great day, one of those sublime springtime moments when all seems right with the world.

But perhaps even more dramatic than the geophysical panorama is the state's social and technological landscape. Agricultural, urban and industrial wealth has poured through these hills and valleys, unleashed during more than a century of accelerated development. The achievements have indeed been impressive. But as this special health issue of the *Rural California Report* reveals, the benefits have not flowed equally to all, particularly when it comes to basic health care.

CIRS recently completed two health assessment surveys of the state's farm workers. Funded by The California Endowment, the California Agricultural Worker Health Survey (CAWHS) and the Binational Health Survey (BHS) provide first-time baseline data on this population, as well as assessing their involvement with health institutions on both sides of the border. The results are striking and underscore the need for a serious public policy response to farm workers' lack of health care accessibility.

Thanks to strong support from The California Endowment and the personal interest on the part of its new President and CEO, Dr. Robert Ross, the CAWHS has received a great deal of publicity across the nation and in California (the BHS report will be released this April). Both CIRS Founder Don Villarejo and myself have been giving presentations regarding the study to a wide range of audiences.

In the midst of all this acclaim, it is important to remember those whose hard work and dedication made it all possible. One of them, Konane Martinez, is an author in this issue. She was Dr. Bonnie Bade's right hand at the Vista and Gonzales field sites. I also cannot say enough about the work of Annie Souter, R.N., Field Site Coordinator in the Mecca, Firebaugh and Cutler sites. She was ably assisted by Laura White during much of that time. In addition to all his other project duties, Project Manager Daniel Williams supervised the Arbuckle and Calistoga sites with help from Maura Dwyer. Finally, I want to pass on a special thank you to our former Associate Director Carol Crabill. These professionals overcame a host of challenges in the process of collecting an enormous volume of data (up to 1,200 data items for each of the 968 subjects). Even more important, the subsequent, painstaking process of data entry, verification and validation revealed that it was high-quality data as well.

Finally, you may have noticed that we've changed our design with this issue. The fresh look comes courtesy of John Nagiecki, our new editor and publications director. He brings his considerable experience in the publishing industry to the CIRS team. We also have a newly designed website, www.cirsinc.org. Credit is due to Associate Director Doug Mihok, who set the whole makeover into motion.

–David Lighthall

Collecting Data, Saving Lives

Field Notes from the California Agricultural Worker Health Survey

by Konane M. Martínez

Vista Community Clinic

Vista, Calif., July 18, 1999 – Ernesto was one of the first agricultural workers to participate in the study. At the physical exam he showed signs of stage-two syphilis that was later confirmed by a blood test. Ernesto's wife and three children lived in Mexico, and he was planning on returning there in four months. With the help of the local clinic and study staff, he enrolled in a program that paid for his treatment.

A second worker, Roberto, tested positive for syphilis the following week. When he did not return to receive his blood work results, I went looking for him. I arrived at his apartment and found a couple sitting at the table eating dinner. "Roberto?" I asked. The man replied, "No, he's not here." I recognized him as Roberto, but didn't challenge him. I merely stated that I was from the clinic. His wife then jumped in, "Yes this is Roberto," giving him a nudge. I explained that I had come to offer him a ride to the clinic, reassuring him that the appointment would be brief.

Roberto hesitatingly agreed to see the doctor, who informed him of the positive results. Roberto's wife and daughter were asked to come in for a test the next day. His daughter's test was negative, but his wife, Norma, who was at that moment four-months pregnant, was positive. Norma had previously been treated for syphilis at another clinic in another county, yet Roberto had not been treated, thus exposing her to the disease again.

Within two weeks of its inception, the CAWHS had helped obtain critical and possibly live-saving medical treatment for the four individuals identified in my field notes, Ernesto, Roberto, Norma and her unborn child. These early cases of sexually transmitted disease later proved to be an anomaly rather than the norm for the study, as few other cases were observed.[1] Nevertheless, their detection and treatment had left an impression on me. I never expected that the project would have such immediate and tangible benefits.

A key component of the CAWHS was the comprehensive physical exam. It served as a prime source of baseline data needed to identify health-care intervention priorities among agricultural workers.

As a research associate for the Vista and Gonzales sites—two of the study's seven locations—my primary role was to coordinate the physical exams. This proved to be a fascinating and enlightening experience. It gave me a crash course in the dynamics of a clinic and allowed me to observe firsthand the interactions between clinic staff and agricultural workers. During my six months in the field, I became a familiar figure in the nurses' area of both clinics. Sitting in waiting rooms, negotiating with the medical personnel and discussing health issues with agricultural workers gave me an inside perspective on the quality of care this population receives.

I had many questions at the start. I especially wondered how people would react to giving blood and answering questions about their personal habits and private histories, if clinic staff would accommodate the project and how we would effectively communicate the results of the physical exams to participants. What I discovered was that agricultural workers are very accommodating, eager to learn about their health status and interested in receiving quality primary and preventive care for themselves and their families.

Facilitating the Physical Exam

The first part of the survey consisted of a 90-minute interview, after which our interviewers helped participants schedule a physical exam. Medical staff at local clinics who had experience serving agricultural workers examined study participants. Blood samples were also drawn at the time of the exam and sent to a lab for a full blood workup. We also asked participants to complete a risk behavior questionnaire, which requested information too sensitive to bring up in the worker's home—such as drug and alcohol use, sexual history, domestic violence and, for women, pregnancy and gynecological history.

I phoned each participant the night before their exam to remind them about the appointment, ask them if they needed a ride, and answer any questions. At both the Vista and Gonzales sites, Bonnie Bade, one of the study's principal investigators, and I arranged to have the local clinic designate a person to perform the exams at special prearranged times. We also rented a car and hired a driver to transport patients to the exam and follow-up appointments.

Project staff greeted worker's arriving at the clinic and brought them to a special waiting room. The medical assistant weighed them, did the appropriate lab tests and placed them in an exam room.

(see **Saving Lives**, *page 11)*

Rethinking Organic Agriculture

by Julie Guthman

California's organic farm sector has changed dramatically over the last 15 years. The number of growers has expanded steadily since 1986, multiplying the state's organic acreage by at least 15 fold. While it still comprises less than 2 percent of crop value statewide, organic food production and distribution has become one of the most profitable and dynamic segments of the agro-food sector.

However, this growth has deepened tensions between the "organic movement"–those who view organic agriculture as a radical alternative to the industrialization of agriculture– and the recently emerged organic industry. Part of the problem is simply economic. A flock of new entrants has stiffened price competition, forcing long-time growers, who have come to depend on organic price premiums, to look for new ways to continue farming without compromising their ideals.

A related issue has to do with the very meaning of "organic." For example, is organic agriculture simply a prescription for avoiding the use of highly toxic and ecologically harmful inputs—the definition that has effectively been embodied in the new USDA rule for organic production—or does it represent a wider critique of agro-food provision, incorporating notions of agro-ecology, locality, scale and perhaps farm-worker justice?

John Nagiecki

Is there a clear choice between organic and conventional food?

Growth and Consolidation

To understand where the organic sector is headed, one has to consider mechanisms underlying the recent growth. Swayed by environmental concerns and their own experimentation with sustainable techniques, some new entrants have embraced organic production. For many growers, however, conversion to organic production is more a reaction to broader changes in the politics and economics of agriculture. Some are looking to grow higher value crops in the face of falling prices and the withdrawal of government support for commodity crops; others are seeking to learn new tools in a changing climate of pesticide regulation; still others are being dragged in "kicking and screaming" by buyers who have an interest in seeing the organic industry grow.

The most dramatic effect of this sort of growth is an extraordinarily oligopolistic industry structure. Key grower-shippers and processors—several of whom helped pioneer organic production—have expanded their operations by joining with conventional growers, claiming, as one buyer so bluntly put it, to prefer to work with professional growers over "hippies." Even small growers have been pulled in this way, as several hundred part-time orchardists—usually farming on residential real estate—sell to packers who promise that the organic designation will bring a return on otherwise marginal value fruit. The most recent round of consolidation has left a handful of buyers controlling a disproportionate share of organic production.

Moreover, cropping, labor and marketing practices have replicated conventional production in several important ways. At the extreme, contract growers specialize in a few crops, relying on labor contractors for their fieldwork and an "input substitution" strategy for soil management and pest control. Even if they were inclined to do otherwise, growers who depend on one or two buyers are forced to mono-crop, making it virtually impossible to integrate agro-ecological ideals that involve complicated rotations for soil fertility and non-crop agriculture for biological pest control.

The existing system of organic regulation, which originated in California, has only encouraged these developments. From the outset, standard setting necessarily involved simplifications, which substantively narrowed the regulatory focus from such broad concerns as water conservation and minimal processing, etc. to production practices alone. The current emphasis on allowable inputs in the form of a "materials list" has encouraged many to practice organic farming in a checklist fashion. Indeed, because of the uneven availability of efficacious inputs for crop-specific pest control problems, "organic" has less to do with how growers manage production than with what crops they grow. Finally, the organic label serves as a financial reward in exchange for the investment of certification and the incremental costs of meeting organic standards. It draws growers in and contributes to the dilution of the very premium production the regulations were intended to uphold.

Beyond Organic

Perhaps directly because of these developments, organic movement growers have been seeking to distinguish themselves under the moniker of "beyond organic." By incorporating an entire set of alternative

(see **Organic**, *page 6)*

Alternatives to the Academic Monopoly

New efforts to connect university and community-based researchers

by Amber López

All knowledge involves a power relationship. In the past, these relationships have served to constrict sources of understanding; however, new initiatives are underway in the Central Valley to redefine what qualifies as "knowledge." The efforts aim to level the playing field between marginalized groups pursuing their own learning and research and academics making exclusive claim to all things theoretical, scientific and knowledge-based.

Two methods, popular education and participatory research, are helping facilitate these changes. Both methods have emerged out of movements around the world that have sought to bring people into collective action and educate them toward goals of social justice. Examples include the folk school movement in Scandinavia, various post-independence movements in Africa and, more recently, the work of adult literacy educator Paulo Freire in Latin America.

Popular education and participatory research are highly flexible techniques, which users have adapted to suit their unique realities. In general, popular education builds on the experience, accumulated knowledge and insight of participants. Activist and UC Berkeley Ph.D. candidate Anne Marie Richard describes it as a community education effort that empowers adults through "cooperative study and action, directed toward achieving a more just and equitable society." Similarly, participatory action research involves community members in generating research questions, gathering data and performing analysis to address repressive conditions in their neighborhoods. Both methods are concerned with those whom John Hurst, professor at the Graduate School of Education at UC Berkeley, describes as "ordinary people," namely the poor, the oppressed, and the marginalized people of the world.

Popular Education

The Pan Valley Institute (PVI), a project of the American Friends Service Committee serving the Central Valley, employs many forms of popular education. PVI uses the method to encourage immigrants to learn more about the cultural and economic realities of their communities, so that they can more effectively engage in civic affairs. Myrna Martinez, project coordinator for PVI, explains that the institute provides "a place where immigrants can come to find support for capacity building and building more expansive networks." This "place" helps them to better understand and work toward resolving the local, regional and international issues that affect them.

For example, the institute brought together a group of 20 immigrant activists to help focus PVI's role in the Central Valley. From this process, participants identified a need to encourage and support immigrant women's leadership and build stronger interethnic relationships. This led to a series of meetings, called Immigrant Women's Gatherings, from different cultural and linguistic backgrounds—including Latina, Hmong and Mixteca. The participants decided to create and publish a calendar, which allowed them to share what they had learned over the past two years working together with the greater community. The 2001 calendar features members of the group and shares their cultural practices and personal stories.

Both CIRS and PVI are part of the Central Valley Partnership for Citizenship (CVP), a learning collaborative of non-profit organizations funded by The James Irvine Foundation. The CVP seeks to improve immigrant civic participation and citizenship in the Central Valley, and has formed the CVP Educational Task Force, which is currently developing a symposium on popular education. The symposium will begin a dialogue between valley education stakeholders on how to expand access to adult education, promote civic participation and improve educational outcomes for immigrants. Task force member Rollie Smith comments, "immigrants are not a population to be filled up with Anglo culture, but a people who have a lot to give to society and the educational process."

The Hmong Educational Task Force, a subcommittee of the CVP Educational Task Force, has contacted UC Merced and will be meeting with the chancellor in the coming months. "UC Merced is a catalyst, it holds the attention of the educational community in the Central Valley," commented Smith. "We hope to influence UCM to see refugee communities as an asset to education in the valley. . . [and] to recognize the Hmong and other cultural groups in the curriculum and perhaps a chair."

"Popular education builds on the experience, accumulated knowledge and insight of participants."

Participatory Action Research

Participatory action research (PAR) crystallized in Tanzania in the 1970s, when the government used the method to involve adults with little formal education in decisions about the country's transition from a colonially dependent capitalist system to a democratic socialist system. Anne Marie Richard says that Tanzania launched a "widespread educational program to help its people participate in envisioning a rebuilt nation and to develop the knowledge and skills needed in order to carry out their vision."

Youth in Focus, a non-profit group that supports youth-led research, evaluation and planning (Youth REP), is using PAR to bring the often ignored "voice," knowledge and experience of youth into programs meant to serve them. The organization has recently branched out in the Central Valley after hav-

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practices, they strive to offer a system of food provision that is much truer to a radical vision. At the extreme end (an ideal not always met), growers integrate livestock, inter-cropping and/or intense mosaic-cropping designs with a high degree of on-farm input development. Those closest to this ideal find that the alternative production practices mesh well with an alternative marketing strategy. For example, direct marketing—through subscription boxes and farmers' markets—requires as diverse a crop mix as possible to always have an array of choices for the buyer. Crop diversity also ensures a more uniform demand for labor through the year. While few organic farms have fully implemented this approach, the strategy nevertheless smooths labor needs, and at least opens the possibility to address entrenched patterns of labor remuneration and conditions in ways that more specialized farms cannot. Their direct marketing focus also creates some of the economic space to do so. Significantly, these farms garner the most devoted customers, who so trust the growers that some are not even certified organic, and others may have dropped the organic designation altogether.

"The national regulatory framework that has been embraced by the organic industry may be inappropriate for achieving broader agro-ecological and social goals."

All this suggests that the national regulatory framework that has been embraced by the organic industry may be inappropriate for achieving broader agro-ecological and social goals. Perhaps more emphasis should be given to extending the reach and availability of research and technical assistance for sustainable agriculture at large, especially given the marked influence of those programs that exist, such as California's Biologically Integrated Orchard System and Biologically Integrated Farming System programs, which, as many growers indicate, offer a more gradualist approach. In addition, these programs seem to encourage biologically integrated practices for their own self-evident agronomic benefits, as opposed to price incentives, although this deserves more systematic study. More fundamentally, additional consideration should be given to technology-forcing pesticide regulation and direct subsidies for ecological farming. These are the sort of policies that will encourage the long-term and widespread adoption of organic techniques as the organic price premium inevitably diminishes.

Julie Guthman, Ph.D. is a Kevin Starr Postdoctoral Fellow in California Studies at the University of California, Berkeley. Her comprehensive report Organic Production in California: Ideal and Real*, can be purchased through the CIRS web site.*

Academic Monopoly

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ing started offices in the Bay Area and Sierra Nevada regions. Co-director Jonathon London stated that "the information that youth generate is important to broader community planning. . . they have something to bring to the data, something adults need, and [the program gives them] a set of skills they can use apart from the data." Youth in Focus staff are currently working toward helping to institutionalize Youth REP among various communities and youth organizations.

New Berkeley Center

The Center for Popular Education and Participatory Research (CPEPR), a research center of the Graduate School of Education at UC Berkeley, is among the relatively new resources available to groups interested in alternatives to academic dominated research and education. CPEPR held their inaugural "Education Across Boundaries" conference at UC Berkeley last November. The gathering was attended by a diverse group of community group representatives, students, academics, researchers and activists from all over the world. The keynote address, "Breaking the Academic Monopoly," given by Budd Hall, a Canadian educator, professor and leading theorist/practitioner of participatory research, stressed the need to dissolve the myth that only knowledge developed within the confines of academic institutions is legitimate. The conference was a strong affirmation of CPEPR's commitment to serve as an epistemological bridge between the university and community-based research groups.

According to Myrna Martinez, CPEPR represents a new and exciting phenomenon for the California university system. Academics like John Hurst, a CPEPR faculty facilitator, has been working with community groups using popular education and participatory research for many years. Nevertheless, few academics share his outlook and often dismiss the methods as outside the bounds of scholarly "research"—such thinking was behind the UC Berkeley administration's initial reluctance to sanction CPEPR as a research center. Nevertheless, the tides are beginning to turn. The James Irvine Foundation, which funds CPEPR, has recognized the center's potential to bridge the gap between the academy and larger society, claiming that the university has as much to learn from the community as the community does from the university.

Martinez's hope is that UC Merced will follow in UC Berkeley's footsteps and actively engage Central Valley communities using popular education and participatory research. Anne Marie Richard, a CPEPR member, has worked with the PVI on a number of projects since before the formation of the CPEPR, and John Hurst was originally involved in the formation of PVI. Richard is also working with CIRS, along with other CPEPR members, to publish a guide to community-based research.

Future Challenges

Popular education and participatory action research practices must constantly be adapted to changing sociopolitical situations. Practitioners of both methods must also be continually mindful of their own cultural values and presumptions, being deferential to a community's values and preferences even when they are in conflict with their own. Practitioners must also keep in mind what Martinez identifies as "the lifelong learning process," and help long-time activists remain open to continually acquiring knowledge not only from other activists and the communities they serve but also from academic experts.

Popular education and participatory research offer hope for bridging the chasm that has traditionally separated the academy from the community. Nevertheless, the divide continues to be regarded by some as necessary for academic researchers to maintain "objectivity." However, this claim of scientific objectivity has been responsible for what Budd Hall calls the academic research monopoly.

But is academic research truly objective? Perhaps so-called transparent methodologies only serve to more cleverly shield rather than reveal embedded assumptions and biases? These are questions that progressive leaders such as Paolo Freire and Budd Hall would have us seriously address.

Popular education and participatory research start where people "are" in terms of their knowledge. These methods may be particularly useful in the Central Valley, given the relatively high English illiteracy, low English speaking ability and low educational attainment as compared to other areas of California. As more institutions and groups provide popular education and participatory research resources to the region, Central Valley communities will have an opportunity to collaborate in developing research and educational projects. This will bring the knowledge and wisdom of immigrants and other marginalized residents into the decision-making process and shape the future of the region.

Sources

Richard, Anne Marie. "Reading the Word: A Critical Look at the Literature on Popular Education," Position Paper #3 (unpublished). April 17, 2000.

Hurst, John. "Popular Education." *Educator*, 19(1). 1995.

Notes

[1] Among Hispanics in the Central Valley, 35 percent are not literate in any language. All but five of the 19 Central Valley counties have a higher proportion of population over 25 years old with less than high school education than California on a whole, according to the 1990 Census.

Unhealthy Bargain

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that, for many, documentation is an obstacle to needed medical care.

Pain Prevalence and Risk

Such low rates of health care utilization among a population often engaged in back-breaking work is disconcerting. Our latest analysis found that over 41 percent of participants reported some form of musculoskeletal pain that lasted a week or more during the previous 12 months. When asked what kind of treatment was sought—from a clinic visit to a non-prescription medicine such as aspirin—71 per cent of men and nearly 69 percent of women reported receiving no treatment whatsoever, not even non-prescription medicine.

Equally surprising was the strikingly high prevalence of health risk factors among the subjects. For example, 81 percent of men and 76 percent of women were either overweight or obese (the latter is defined as a body mass index greater than 30). Overall, 53 percent of the men and 46 percent of women had one or more of the following chronic disease risk factors: obesity, high blood pressure or high serum cholesterol. The physical exam and blood chemistry data also revealed significantly elevated rates of anemia for male workers. All of these indicators point to work demands (for example, lack of time to obtain and cook nutritious food) and dietary habits as major underlying causes. The high rates of obesity are consistent with recent evidence of this problem found across the low-income minority population of the United States.[3]

Since the publication of the CIRS report *Suffering in Silence* in November 2000, further data analysis raises the question whether chronic risk factors are related to time spent in the United States. For example, we found that the rates of high cholesterol were much greater among documented farm workers (25 percent) versus undocumented farm workers (4 percent). One logical explanation was a difference in age—most likely the documented workers were older and this was reflected in the data. The average age for the male documented and undocumented workers was 40 and 30 years, respectively.

Closely related to worker age is the length of time since workers first entered the United States. Ethnographic fieldwork conducted by CIRS's Binational Health Survey (BHS) indicates a need to study the possibility of a functional relationship between workers' exposure to a California based diet, working patterns, exercise, lifestyle and their overall risk to chronic disease. Further analyses will address the hypothesis that time in the United States is a risk factor for the farm worker population, which could have much greater outreach implications than age alone.

"California and the federal government simply cannot continue to turn their backs on the goal of universal health insurance."

Unfortunately, we were not able to collect fasting glucose measures from participants during their physical exams, so the study was not able to assess the degree to which participants were at risk for diabetes. However, given that health researchers have discovered both the hormonal link between adult-onset diabetes and obesity, and that persons of Mexican, Afro-American and Native American decent are genetically predisposed to the disease, we can assume that California's largely Latino farm worker population is particularly at risk to the disease.

Averting a Crisis

Overall, the evidence from the California Agricultural Workers Health Survey (CAWHS) and the Binational Health Survey (BHS–see accompanying article) indicates a looming public health crisis for California's rural regions in general and the

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Central Valley in particular. To this we can include Los Angeles and other cities with sizable populations of underinsured, low-income residents. California and the federal government simply cannot continue to turn their backs on the goal of universal health insurance. So while it is obvious that health insurance is not a sufficient means for addressing this long-term issue, it is certainly a necessary component. From the larger perspective of sustainable development, it is hard to imagine California achieving that goal in the absence of universal access to health insurance.

Now for the good news. First, there is nothing inevitable in these trends. The chronic disease related problems documented by the CAWHS and BHS studies are preventable. Second, California's health care foundations are making significant investments in addressing the larger problem of health disparities among its population. In the case of The California Endowment, their willingness to fund these two research projects has laid a foundation for addressing farm worker health in a comprehensive manner. A case in point is the Endowment's formation of a blue-ribbon task force on farm worker health composed of experts spanning the public, private and research communities. The task force has been asked to prioritize programmatic objectives for the foundation as well as develop a set of prospective legislative initiatives, all to be released in spring 2001.

One can argue that California's foundations, in general, are playing a critical role in forcing a reluctant government and its citizenry to address its deep-rooted barriers to sustainable development. In the case of farm worker health, CIRS has been able to document a new set of unintended consequences of our food system that simply cannot be ignored. As I have argued in previous articles in this journal, it is critical that both our analysis of the problem and our search for solutions be based on a broad food system analysis rather than a narrower focus on agriculture. Do we need more incentives for employers to provide their workers with health care? Yes. Do we need more effective enforcement of farm labor laws? Yes. But we also need a public debate about diet and public health that reaches every resident of this state. It will not be easy or comfortable for it will inevitably be a public debate about what we typically regard as private choices.

In closing, I can't help but note the contrast between our findings and the current tax cut debate in Washington, D.C. From the perspective of most health care providers, public health researchers and health care advocates, the true fiscal surplus of the U.S. government cannot be measured until we have addressed the problem of 40 million uninsured citizens. For others, it is a question of "giving the people their money back." Given that the prevailing Zeitgeist of self-entitlement favors the latter perspective, the challenge to CIRS and like-minded researchers will be to conclusively demonstrate the long-term cost-effectiveness of universal coverage. The baseline data generated from the CAWHS, BHS and other studies are, we hope, laying the foundation for achieving this goal.

–David Lighthall and Kenneth Kambara

Notes

[1]See *Affordable Health Care for Low Income Californians: Report and Recommendations of the California Citizens Budget Commission*. Center for Government Studies, Los Angeles. 2000.

[2]See "A Food System Approach to the Farm Worker Problem" (RCR, Fall 2000) for a fuller explanation of agriculture's weak position within the food system and how this contributes to low-wages and benefits for farm workers.

[3]For a summary of the health-related impacts of obesity and a review of recent trend data see, the Diabetic and Hypertensive Nephropathy Research Center website, www.diabetes-hypertension.com/obesity.htm.

[4]See "Hormone Link Between Obesity, Diabetes Found" and "Gene Mutation Sheds Light on Diabetes Cases" by Thomas Maugh II, *Los Angeles Times*. Reported in *The Sacramento Bee*, January 18, 2001 and September 27, 2000, respectively.

[5]An example of another baseline health survey directed at all Californians is the California Health Interview Survey. Conducted by the UCLA Center for Health Policy Research, the cross-sectional CHIS will interview 55,000 California households regarding a comprehensive range of health issues. For more information see: www.healthpolicy.ucla.edu/chis/

BHS

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chosen workers from seven villages in the state of Zacatecas in northwestern Mexico and their filial communities in the United States.[1] Launched in January 2000, the 12-month study also involved extensive field observations with key respondents and health care professionals on both sides of the border. The observations provided detailed information on how farm workers cope with the many health care challenges they face.

Insurance Coverage

As in CIRS's California Agricultural Worker Health Survey (see "Suffering in Silence"), the BHS showed that more than half (56 percent) of the respondents had no medical insurance. Within households, 15 percent had insurance coverage for themselves only, 26 percent also had coverage for thelselves and their families and 9 percent had plans that covered only their family members. This latter group refers mostly to undocumented parents who have children born in the United States.

Twenty-three percent of those surveyed were covered by their employer's insurance, with only 14 percent relying on this insurance to cover costs. Moreover, many employer programs require minimum earnings per month to qualify, drop workers seasonally and ask workers to make matching payments.

Low-income health insurance is another option for farm workers, many of whom easily fall below the programs' income ceilings. However, few farm worker individuals or families enroll in these programs, with only 19 percent of BHS respondents indicating that their households were Medi-Cal recipients (only 12 percent relied entirely on Medi-Cal to actually cover payments).[2] Among households with at least one U.S.-born child under 21 years of age, 70 percent did not have any members covered by Medi-Cal.

These numbers are surprising given that many low-income insurance programs specifically target these populations. Previous research has shown that confusing eligibility criteria, a complex application process and other structural factors—such as clinic proximity, inadequate transportation or language barriers—tend to discourage farm workers from enrolling in these programs.[3] Two other factors contributing to the low numbers include

the failure of farm workers to keep up with premiums—required by some low-income public programs—or submit regular income eligibility updates, which in the case of Medi-Cal are required regularly.

The receipt of mailed invoices several weeks after treatment is another problem that has stigmatized low-income insurance programs among this population. Though these invoices often require no payment—showing a zero balance—they are frequently misunderstood, leading some patients to believe that they have been misled, if not hoodwinked, by the public agency.

Patchwork of Care

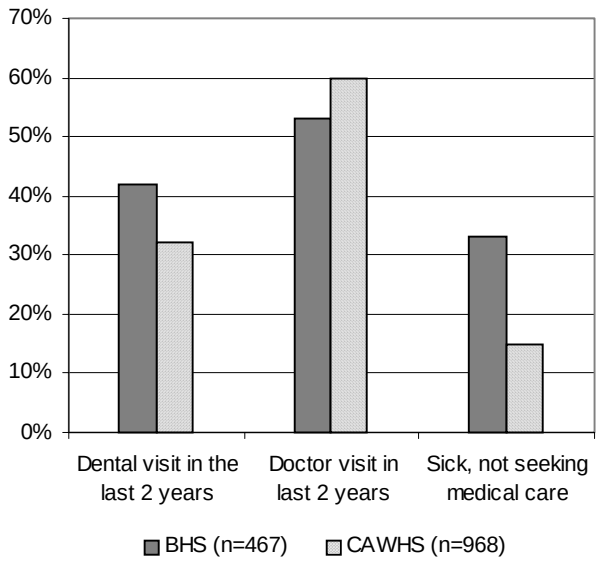
Most of us would prefer to have a wide variety of options when it comes to our health care, with the freedom to pick the primary care physician or specialist of our choice. However, farm workers face a different reality. They rarely have a primary care doctor who coordinates their treatment. Instead, their health care is scattered across a broad mosaic of providers on both sides of the border.

But without a "routine provider" there are few opportunities for personalized care. Medical records, if they exist at all, are distributed across many clinics and offices, with no information shared among physicians. The situation severely hampers opportunities for follow-up visits or preventive treatment and often results in farm workers waiting until symptoms become intolerable, which increases both health risks and costs to the patient and the society. Perhaps most vulnerable to the effects of such dispersed care are elderly farm workers.

Over one quarter of the BHS respondents mentioned using two or more treatment providers, regardless of whether they sought care in the United States or Mexico. In the United States, 45 percent of the respondents reported that they combined private physician treatments with other care. In rural Mexico, where the majority of the population lacks any form of health insurance, 47 percent of those surveyed received all of their treatment from a private physician, and 74 percent combined private physician treatments with that of other providers.[4] The Secretaria de Salud (Secretary of Health) offers low-cost or no-cost treatment at public clinics; however, only 13 percent of the families surveyed sought treatment at these clinics. Approximately one-third of these combined treatment at government clinics with that of a private clinic.

Insurance coverage for prescription medicine is also uncommon. Pilot research has shown that a variety of Hispanic immigrants (including Mexican immigrants) frequently purchase lower-cost prescription medication from Mexico.[5] They also prefer doctors—primarily Mexican—who will give them the type of medicine they prefer, namely, those "strong" enough to cure them.

Figure 1. Doctor and Dentist Visits Over a Two-year Period



Given the widespread lack of insurance coverage, how does this population cover the costs of private treatments and medicine? The BHS determined that approximately two out of five farm workers (38 percent) in the United States choose to pay in cash, while four out of five (81 percent) workers in Mexico pay for medical care using out-of-pocket cash.

Across the Cultural Divide

In the United States and Mexico, farm worker communities rely on well-developed information networks, whereby individuals discuss and obtain advice from their peers and family members on how and where to obtain medical treatments. But these networks do not help when it comes to dealing with the health care bureaucracy. Instead, these community networks—which are quite insular—tend to reinforce traditional rural Mexican attitudes about medicine, mistrusting the unfamiliar organizational and procedural practices common in the U.S. system. For example, in Mexico patients usually receive immediate treatment based on a physician's physical examination and without the delay of more involved (and expensive) laboratory tests. Experience with this "direct" system tends to cast doubt among immigrant populations on the efficacy of the more protracted and test-intensive U.S. approach, and farm worker networks tend to amplify this doubt.

Community networks also provide individuals with information on which U.S. physicians deliver quick "Mexican-style" treatment or which border physicians are willing to prescribe medicine quickly and without paperwork. In addition, the community sources of information tend to downplay prevention and the need for obtaining year-round health insurance, as well as promote misconceptions regarding eligibility (or immigration) policies in the United States. Such circulating information tends to reinforce resistance to the practices and procedures of U.S. institutions or agencies.

The Next Steps

The BHS study demonstrates a need to rethink existing approaches to farm worker health care. Both institutional obstacles and attitudinal barriers discourage farm workers from obtaining quality care in either the United States or Mexico. The immigrant networks have excellent information systems for finding employment via a system of informal labor market intermediaries, but have a difficult time informing themselves about or accessing institutional programs. Low-income public insurance programs could better serve this client population by making eligibility more straightforward, streamlining the application processes, tailoring requirements to meet farm workers' lower threshold for paperwork, as well as meet needs arising from

(see **BHS**, *page 10)*

California's Low-income Health Care Programs

Medi-Cal. The California Department of Health Services administers California's Medicaid program, known as Medi-Cal. Funded by both the state and federal governments, Medi-Cal provides no-cost health coverage or a share-of-cost program to low-income families—most recipients do not have co-payments or premiums. CalWORKS, SSI/SSP recipients, families below certain federal poverty level cut-offs and pregnant women qualify for Medi-Cal.

Healthy Families. Healthy Families provides health care coverage for children ages 1–19 in families with income levels that exceed the eligibility level for Medi-Cal (and do not exceed 250 percent of the federal low-income guidelines—$35,376 for a family of three). Funded by the state and federal government and administered by California's Managed Risk Medical Insurance Board, Healthy Families bases premiums on family income, and co-payments are required for certain services.

Major Risk Medical Insurance Program. MRMIP covers California residents not eligible under Part A or Part B of Medicare, who have been denied individual health coverage within 12 months. MRMIP is funded under California's Proposition 99 and administered by the Managed Risk Medical Insurance Board.

Medicare. Administered by the federal Health Care Financing Administration, Medicare targets citizens or residents 65 and older, the disabled (under 65 years of age), persons with chronic renal disease, persons eligible to receive SSI or those receiving benefits from the Railroad Retirement Board. Medicare involves premiums, deductibles and co-payments.

Child Health and Disability Program. CHDP offers health screenings and immunizations to uninsured, low-income children. Funded almost entirely out of California's general fund, CHDP covers children up to 19 years of age whose family income levels meet federal poverty requirements.

California Children Services Program. Administered by the California Department of Health Services, CCS provides medical care for children under 21 with chronic or severe illnesses. Co-payments are based on family incomes.

BHS *(cont. from page 9)*

their seasonal employment and mixed family immigration status.

Equally important is the need to bridge the cultural divide by educating farm workers with regard to U.S. medical practices and procedures as well as training service providers on how to better meet the unique needs of this population. A crucial element will be to expand the cadre of trained case-manager intermediaries, whose knowledge of immigrant families' special circumstances enables them to find programs that match the health care needs of this population.

–Rick Mines, Lisette Saca, Nancy Mullenax and John Nagiecki

Notes

[1]The BHS was a pilot study aimed at measuring the health care status of current and former farm workers of Mexican origin who have worked in U.S. agriculture. The pilot demonstrated that by working inside transnational immigrant networks that originate in single towns in Mexico, one can obtain reliable information based on a process of confidence building within a community of people who know each other well.

The survey sample was randomly chosen from lists of all eligible people raised in one of seven villages in southern Zacatecas, who had worked a minimum of two seasons in the United States as farm laborers, regardless of where they were living at the time. The lists, which ranged from 94 to 302 eligible individuals per village, were created during interviews with town leaders over a one-month period in late 1999.

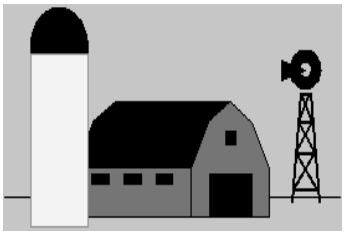
The study sample was selected by juxtaposing a random number series alongside the lists. Of the 1,123 people on the lists, 467 were randomly chosen for the study, or about 42 percent. A total of 305 interviewees were selected in the villages and 162 additional interviewees were picked from the universe lists in the U.S. sister communities. By sampling from unified binational lists on both sides of the border, the method assured a representative sample of individuals living in the transnational community.

[2]The U.S. Department of Labor's National Agricultural Workers Survey demonstrated that approximately 60 percent of California farm workers earn below the poverty line. Nearly all fall below the Healthy Families program's income ceiling—250 percent of the federal low-income guidelines, or about $35,376 for a family of three.

[3] Diringer, J., Ziolkowski, C. and Paramo, N., "Hurting in the Heartland: Access to Health Care in San Joaquin Valley, A Report and Recommendations," California Rural Legal Assistance Foundation, 1996, Sacramento. Azevedo, K., "Medical Insurance Coverage and Usage Among Farmworker Families: A Case Study," California Policy Research Center Brief.

[4]In addition to licensed Mexican doctors and dentists, farm workers seek treatment from Mexican *curanderos*, namely, massage therapists, herbalists, and other similar alternative treatment providers.

[5]Casner, P.R., Guerra, L.G., "Purchasing Prescription Medication in Mexico Without a Prescription, The Experience at the Border," *Western Journal of Medicine* 1992; 156:512–516.



Saving Lives

(cont. from page 3)

Afterwards, we thanked the workers for their time and presented them with a financial stipend and a certificate of acknowledgment. We also scheduled them for a follow-up appointment to receive the exam results and blood work.

Communicating Results

At the follow-up appointment, workers met with a medical provider to discuss their results. *"Gracias a Dios"* (Thanks to God) was a common response to a clean bill of health. Of course, the exchange did not always go so smoothly.

In one case, a worker named Manuel disagreed with the advice he had been given, and thought he was being deceived by clinic staff. The bilingual, bicultural medical assistant had told him that his cholesterol level was a little high, and that he could lower it with a change in diet. She gave him a sheet of paper showing two charts that broke down the calorie and fat content for foods such as butter, lard, cooking oil and bread. If he avoided foods on the left of the chart, she said, and switched to foods on the right, his cholesterol levels would improve. The charts were in English, printed in very small type, and included some foods that Manuel had never heard of. Other than this chart, the medical assistant did nothing to help him understand what his cholesterol level meant.

"She's lying to me," he told me, "Look at me, I know I'm fat and have high cholesterol, but they don't want to help me here, they don't care." I informed the assistant of the misunderstanding and she spoke with him again, but Manuel was still not satisfied. He told me that he would see a private doctor in Mexico that would help him with his cholesterol. He left the clinic frustrated.

I witnessed this type of frustration several times while in the field. The clinic's fast-paced environment and lack of appropriate health education materials often served to alienate agricultural workers as well as hinder their interaction with clinic staff.

Barriers to Care

Agricultural workers often do not have access to health care because of lack of health insurance, poverty and legal status. Inconvenient clinic hours, language barriers, inadequate transportation and poor patient-provider interactions also discourage them from getting the care that may otherwise be available to them.

I often observed how these factors came into play. For example, I frequently faced the task of trying to convince reluctant workers to seek follow-up care when the results of their physical exam showed a possible problem. I carefully explained the health-care services available to them, remaining conscious of the need to minimize barriers. In one case, I told a participant at the Gonzales clinic who had been diagnosed with diabetes to contact an outreach worker from a nearby town, as his local clinic had no programs to serve him due to his legal status. He asked me what it would cost to go there and how to make an appointment. I assured him that the outreach worker could answer all of these questions and would do as much as she could to help him get free or low-cost service. Though I tried my best, I don't think I assuaged his concern about the expense and trouble, and I doubted he ever made the appointment.

> *"I observed several instances of Mixtec workers from Oaxaca, Mexico not receiving the attention they needed. "*

Another patient at the Gonzales clinic, whose elevated glucose level indicated diabetes, refused treatment for the problem. He insisted that he felt fine. He also stated that he could not afford to miss work in order to drive to Salinas, where there was a doctor who could assist him. I was upset that I was unable to help him understand his diabetes diagnosis or offer him more immediate assistance in accessing care.

Finally, though I expected language to crop up as a barrier, I didn't anticipate how nuanced a problem it could be. Though having a Spanish speaker on the medical staff is helpful, it is not always enough. An increasing number of agricultural workers in California are comprised of indigenous peoples from southern Mexican states and Central America. I observed several instances of Mixtec workers from Oaxaca, Mexico not receiving the attention they needed.

For example, Juan, a recently immigrated Mixtec, arrived at the clinic with his brother-in-law, Pedro. The latter told me that he would translate for his brother, who spoke primarily Mixteco and very little Spanish. I explained the situation to the medical assistant, who did not understand why Juan needed a translator. She, in turn, dismissed the complexities of Juan's situation, and simply told the doctor that he spoke some kind of dialect.

Looking Back

Working in the south coast and central coast field sites taught me much about the daily lives of agricultural workers and the challenges that they face in accessing and utilizing health care. I learned as much about survey methodology as I did about the functioning of the health care clinics. Most importantly, however, I learned from the agricultural workers themselves. I learned about how difficult it can be to access care while attempting to negotiate one's place within the political, social and economic environment of California's agricultural communities.

In conclusion, I feel that agricultural workers greatly benefited from participating in the study. One participant commented, "Thank you for so much not only for the money that you gave us but for the opportunity to know about our health." Indeed, such knowledge represents an important first step. Hopefully the study's findings will aid health care providers and insurers in instituting the necessary changes to ensure that all agricultural workers have the same opportunity.

Konane Martínez is currently completing her Ph.D. in anthropology at the University of California, Riverside. Her dissertation examines the ways in which transnational Mixtec families access and utilize clinical health care services in both San Diego California and the Mixteca region of Oaxaca Mexico. (konane@citrus.ucr.edu)

Notes

[1] Breast cancer , severe diabetes and other potentially fatal illnesses were detected during the physical exam at several other CAWHS sites.

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The first social science study of organic agriculture in California. The report examines the development and contemporaray character of the California organic sector, the influence of existing and proposed regulatory structures, and key patterns and trends in producer practices.

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