

MIGRANT HEALTHCARE IN NORTH CAROLINA: WHERE WE ARE AND
WHERE WE SHOULD BE.

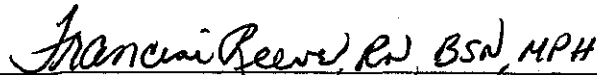
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Abstract

It is estimated that forty five million Americans lack health insurance (DeNavas-Walt, Bernadette & Mills, 2003). There are more than 40 million Latinos living in the United States (US Census, 2004). As part of this problem, most of the Latinos living in the United States lack health insurance as well (Institute of Medicine, 2001). Despite major technological advances in the medical field, access to healthcare is one of the greatest challenges of the modern era in the US. Healthcare costs have been on the rise, while at the same time, people with adequate health insurance have been decreasing (Employee Benefit Research Institute, 2004).

Moreover, Latinos represent the largest minority group in the United States (US Census, 2004). North Carolina has experienced a rapid increase in the Latino population in the last ten years, from 1.04 percent to 4.7 percent (NC Latino Health, 2003). Specifically, this is due to migration patterns of workers and a high birthrate among Hispanics.

Despite technological advancements in the agriculture and farming industry, manual labor is still needed. This strenuous physical work that pays low wages but requires high risk makes it undesirable for many. People that want to migrate to the United States see migrant work as a golden opportunity. They want to be able to live and work in better conditions than the ones that exist in their county of origin. Many are also trying to escape from economic depression and possible political or religious discrimination. Medical care provided to migrant workers has been largely limited to

treating acute medical conditions, mainly due to occupational illnesses. Thus, their birth rate is high due to lack of access to family planning services. Conversely, the medical needs of migrant workers have increased over time as more chronic medical conditions have developed.

Multiple factors are associated with the health disparities seen in the Latino migrant worker population in the United States. These factors of health disparities include social factors such as low income, inadequate housing, limited education, violence in the communities, and restricted access to recreational activities (Vines & Godley, 2004). In addition, culturally specific barriers to healthcare are also present, such as cultural beliefs, language barriers, and a lack of healthcare facilities with cultural competency for the Hispanic community (Vines & Godley, 2004). Multiple venues provide some form of primary healthcare to Hispanic migrant workers and their families, but these efforts are limited in the number the venue can absorb scope of practice, and language and cultural competencies (Vines & Godley, 2004).

The best setting to provide adequate primary medical care to the Hispanic community is within competent, specialized clinics that understand the unique needs, culture, and language barriers of the Latino population, with the cultural competencies that will in turn assure adequate delivery of preventive and medical care. Those specialized clinics should be made accessible to Hispanic migrant workers and their families in order to facilitate the timely delivery of basic medical treatment, including medications, education on health prevention, and access to secondary and tertiary medical care.

Latino Migrant Workers in North Carolina

North Carolina is an agricultural state. The United States Census of Agriculture from 2002 indicated that the state of North Carolina had 53,930 farms, occupying more than nine million acres (USDA, 2002). The estimated market value of land and building per acre is more than three thousand dollars (USDA, 2002). The market value of agricultural products sold amounts to close to 7 billion dollars (USDA, 2002). Moreover, North Carolina is the primary producer in the United States of Flue-Cure tobacco, total tobacco, and sweet potatoes. Additionally, North Carolina is the second highest state in the production of hogs and pigs, Christmas trees, and turkeys (NC Dept. Agriculture, 2004). Agriculture and related activities provide close to 10% of the state's economy (Friedenberg H.L., Beemiller R, 1994).

In the United States, 81% of all farm workers are foreign born, primarily recent Mexican migrants (Mines, Gabbard & Steirman, 1997). Eighty percent of these are male, mostly between 25 and 34 years of age (Mines, Gabbard & Steirman, 1997). The median education is at a 6th grade level, and at least half of them migrate within one year either to another location inside the US or internationally (Mines, Gabbard & Steirman, 1997). One third of these migrants have an unauthorized migratory status (Mines, Gabbard & Steirman, 1997). In addition, 20% were covered by unemployment insurance, but only 5% were covered by health insurance through their employer (Mines, Gabbard & Steirman, 1997). About 75% earn less than ten thousand dollars per year (Mines, Gabbard & Steirman, 1997). North Carolina is one of the top five states in the nation for

the number of hired farm workers, 27,000, or about 4 % of the U.S. hired farm workers are in this state. Out of those, about 42% are Hispanic (USDA, 2006).

Migrant Workers Limited Access to Healthcare

This Hispanic population presents multiple challenges in terms of healthcare. For instance, Hispanics have greater incidences for readmissions to hospitals due to diabetes (Jiang J., Andrews R., Stryer D., Friedman B., 2005), have increased incidences of maternal mortality (Hopkins F, Mackay A, Koonin L, Berg C, Irvin M, Atrash H., 1999), have later-stage disease presentation of breast cancer (Boyer-Chammard A, Taylor TH, Anton-Culver H., 1999), along with multiple other examples of poor health outcomes.

There are additional, unique health concerns of the migrant worker population. Poor nutrition, inadequate sanitation related to overcrowding, active tuberculosis, high risk pregnancies, and under and over immunizations are also found in the migrant population (Migrant Clinics Network). Depression and substance abuse is also a concern, as economic, cultural and political pressures are ubiquitous (Migrant Clinics Network). Occupational hazards are also prevalent as most migrant workers frequently perform sustained physical tasks in the open field and operate large, heavy equipment. These occupational hazards include eye injuries, skin injuries, insect bites, muscle strains, carpal tunnel syndrome, and pesticide exposure (Migrant Clinics Network). Additionally, exotic diseases or those conditions commonly present in Third World Countries and rarely seen in the United States are often present in the migrant population. Such conditions are mainly parasitical, and include shistosomiasis, shigellosis, salmonella, amoebic liver disease, brucellosis, yellow fever, polio, and others (Migrant Clinics Network). However, data to monitor occupational injuries is hard to obtain and follow

due to the lack of centralized care, lack of social security numbers, change of names by the workers, and the migratory patterns they follow (Migrant Clinics Network). The fact that migrant workers have an increased incidence of parasitic infections and that by virtue of their employment they migrate through the United States, prevention, diagnosis, and treatment of these workers is a major public health concern.

Latino Migrant Worker Health Disparities

It is clear that much of the health disparities associated with migrant workers and their families is due to inadequate access to healthcare services. This results from social and cultural factors such as lack of affordable medical services and lack of a culturally sensitive approach. In as much that only 5% of farm workers have health insurance (Camarota S., Edwards J., 2000), it is reasonable to conclude that most of the barriers to healthcare are related to direct access.

Public Perception Versus Truth

It has been asserted in the public arena that providing health insurance to migrant workers has "limited value ... in an economy that increasingly demands educated workers" and that providing insurance to immigrants is "at the taxpayer expense" (Camarota S., Edwards J., 2000). Additionally, cultural feelings from the main stream majority populations have led to proposals to block non-emergent medical care to undocumented immigrants, such as Proposal 18 in California and the 1996 Personal Work and Responsibility Reconciliation Act that made most immigrants entering the United States after 1996 ineligible for Medicaid for five years after entry (Personal Responsibility and Work Opportunity Reconciliation Act, 1996).

However, the opposite may be closer to the truth. Migrant workers contribute ten billion dollars to the U.S. economy per year (Smith JP., Edmonton B., 1997).

Additionally, each migrant worker will pay an annual average of \$80,000 per capita more in taxes than they will use in government services over their lifetimes (Smith JP, Edmonton B., 1997). Moreover, the estimated economic impact of workers without a valid social security number is 8.5 billion dollars to Social Security and Medicare (Porter E., 2005). In North Carolina, it has been estimated that Latinos had a buying power of \$8.8 billion in 2002 (Humphreys J., 2002). This level of expenditure generates close to 90,000 jobs.

In North Carolina, the general feeling is that illegal workers are costly. It is estimated that illegal immigrants compose nine percent of the work force in North Carolina (Employment Security Commission). For example, people view the expense associated with the education of their children costly, and the expense of health costs related to emergent and urgent healthcare for workers and their families in lieu of more cost-effective primary care costly (News and Observer, 2006). There is also a sentiment that migrant workers displace legal residents from jobs because they are willing to work for lower wages (News and Observer, 2006). The Hispanic population in North Carolina has increased dramatically in the last ten years. It is estimated that the Latino population grew by 400 percent between 1990 and 2000, more rapidly in North Carolina than in any other state in the United States (US Census). This significant growth can be attributed to a high migration rate from Central America and to the high birth rate of the Hispanic population that is already here (Silberman P., et. al., 2003). It is estimated that North Carolina has a total of 600,900 Hispanics, out of which 395,000 or about 65 percent, are

illegal aliens (Pew Hispanic Center). This pattern of growth varies by county. However, from 4 to 7 percent of each county in North Carolina is identified as Hispanics (US Census).

Hispanics generate \$1.9 billion dollars in savings to payrolls annually and produce goods and services at a lower cost to industry with savings passed on to the consumer (Kasarda J., Johnson J., 2006). Despite that positive economic profile, it has recently been estimated that all Hispanics, legal and illegal, cost taxpayers \$817 million in 2004 while generating only \$756 million in tax revenue, creating a deficit of \$102.00 per Hispanic resident (Kasarda J., Johnson J., 2006). However, those numbers are inconclusive as they do not separate legal and illegal immigrants.

Population Assessments

Some efforts to identify the social and health needs of the Hispanic community, such as population assessments, have been undertaken by different organizations. However, those assessments are limited by several factors. One limitation is a lack of a clear channel to communicate with the Hispanic community. While the main population shares local TV and radio channels, the Hispanic community often does not have access to it statewide. Some local radio stations provide exclusive programming in Spanish, but these areas are limited to communities with a large Hispanic population. The only local television station in North Carolina geared to the Latino community is located in Raleigh, and it is not generally accessible through the state.

A second barrier for adequate assessment is fear illegal migrant workers have of congregating in a specific location due to the possibility of arrest and deportation by

federal immigration officials. To compound this problem, some Hispanics modify their names to make it difficult for federal agencies to track them. Their intent is to try to avoid federal prosecution if arrests are made multiple times for the same person and a criminal record is created. The problem with hidden identities is that adequate follow up of patients is difficult as there is not a name, a social security number, or sometimes a reliable date of birth for the same person. Therefore, any follow up on those patients depends on the stability of the community. The Migrant Clinicians Network, a not for profit organization that provides support, technical assistance, and professional development services to clinicians working in migrant health, has assembled three different tracking programs under one umbrella (TBNNet, TRACK II and CAL-track) into the MCH Network (Migrant Clinicians Network). By doing this, patients are provided with a single identification number that is shared by the three tracking systems. It also helps with name identification, as the system will use a single name for the patient (Migrant Clinicians Network).

Lastly, migration patterns for work opportunities impede adequate population assessments as follow up is limited to community members that do not follow these migratory patterns. Some jobs provide greater stability such as construction and the service industry, for example restaurants and hospitality services (Kasarda J., Johnson J., 2006). However, some of the jobs performed by migrant workers are generated by the agriculture sector. Even in the agriculture sector, there are some opportunities for migrant workers to stay in one place. These include employment on hog and turkey farms and tobacco farms (Mines R., Gabbard S. & Steirman A., 1997). However, most agricultural jobs are cyclical during the year, and workers are dependent on the needs imposed by the

product involved. The pay structure of migrant workers obligates them to work most of the time during the year, as income depends on the hours they actually work. Therefore, migrant workers move place to place so they can work at all times. As in North Carolina, some crops need farm workers at some times more than others. Therefore, some workers will move to other counties or even states "following the crop" (Mines R., Gabbard S. & Steirman A., 1997). Those migration patterns not only affect the migrant worker, but the entire family. In those cases, an adequate assessment that requires not just a snapshot, but a realistic trend of problems, is close to impossible.

Social Factors

Poverty is another barrier to healthcare for the Hispanic population in North Carolina. Most Hispanics families in the United States are living in poverty, with an average annual income of about \$10,000.00 per year (Kasarda J., Johnson J., 2006). Some families send money to relatives in their native country to help sick relatives, reducing the funds that they can use for healthcare. Additionally, housing is mainly provided by the farm where the migrant workers work. Typically several families may share a single dwelling, which creates problems secondary to hygiene and overcrowding (Migrant Clinicians Network). Thus, low income and inadequate housing are serious barriers to healthcare for the Latino migrant population.

Poor health literacy compounds the problem of access to primary healthcare. It is generally accepted that reading comprehension may be low in certain parts of the United States population. Lack of basic skills to read and understand even simple written or oral instructions further hinders medical care. Considering that most migrant workers have a

low level of education, coupled with a different language, literacy is a real barrier in obtaining and following up on healthcare.

Most Hispanics have no medical insurance at all. They may be covered in some industries for direct injuries at work, but not for other chronic medical conditions. Although migrant workers may be income eligible for some assistance programs such as Medicaid and food stamps, federal laws prohibit assistance to illegal immigrants for the first five years after becoming legal immigrants (The Personal Responsibility and Work Opportunity Reconciliation Act of 1996). Children born in the United States, on the other hand, are covered by their individual state Medicaid system. However, some Hispanic parents do not enroll their children as they do not want to burden society. In North Carolina, 14% of non-Hispanic whites are uninsured, compared with 19.9 % of African Americans, and 55.7% of Latinos (Holmes M., 2004).

Access to healthcare is also limited by the hours of operation of most regular healthcare clinics. Farm workers are hourly paid employees. Most farm labor is done during the day. This conflicts with the hours of operation most physicians' offices which are only open during these same hours that farm workers are required to perform their work.

Transportation is a huge barrier as well. The majority of migrant work sites are located in remote rural areas, creating a physical barrier in obtaining medical care. To obtain a driver's license in the State of North Carolina, a person must present adequate identification, along with other requirements. This personal identification may include Immigration and Naturalization Service (NCDOT) documents or a Matricula Consular from Mexico (NCDOT). This may create problems for non-Mexican migrants that are in

the United States without INS documents. Additionally, other requirements to obtain a valid driver's license include proof of a current residency address (NCDOT). That requirement may be hard to meet as some families live together and utility accounts are in the farm owner's name. The hardest requirement for licensing is proof of insurance. With high car insurance costs and low income earned by the migrant workers, it is hard for them to obtain and maintain auto insurance. For all of these reasons, most Hispanic farm workers do not own a vehicle. Most frequently, one member of the community has a car and other members of the community share it.

Since most farms are located in rural areas of the United States, access to medical specialists and specialized medications and equipment may be a barrier to healthcare. Differences in medical competency of providers also limit adequate access and follow up of health care.

Cultural Impediments to Healthcare

Cultural beliefs may be another barrier in obtaining healthcare in the United States. For some Hispanics, illness is thought to be associated with an "evil spirit" requiring not medical care, but the help of "curanderos" who employ prayers and lotions (Migrant Clinician Network). This cultural barrier presents a real problem, especially to children with febrile illnesses, as these illnesses may have serious and lasting consequences if left untreated. In addition to those beliefs, Hispanics may have problems establishing trust with their medical team. Furthermore, a lack of self-disclosure or not revealing intimate details related to risky behavior may exist, as Hispanics do not want to hurt their family members with an account of risky behavior. Lastly, Hispanics

communicate in a rather soft, indirect manner. They will avoid eye contact as direct eye contact may be perceived as threatening. Machismo, either real or perceived, may be a communication barrier, especially with young female patients. Additionally, slang used by different groups of Hispanics may have different meanings in different contexts creating confusion. Finally, the concept of formal versus informal language may also create a barrier in obtaining healthcare and follow up. Hispanic language and culture make clear distinctions on how to address people formally or informally. Regrettably, most of the medical providers with some knowledge of Spanish only use the informal aspect of the language. This may create confusion and distrust among the Hispanic community as they perceive healthcare as a formal occasion (www.hisp-med.com).

Reality of Migrant Worker Healthcare

For all of the reasons discussed, some migrant farm workers receive urgent and emergent medical care in the Emergency Departments (ED) of local hospitals. Language, cultural, and economic barriers play a role in terms of the adequacy of medical care provided in the ED. Medical care rendered in the ED is geared to treatment of acute medical problems and not sub-chronic or chronic medical conditions (American College of Emergency Physicians, 2002). This reduces the opportunity for adequate diagnostic tests and long term medical treatment. Emergency Departments do not dispense medications for chronic conditions; therefore, patients have to go to the local drug stores to purchase the prescribed medications, creating another potential conflict for language and cultural friction, as well as creating an economic burden for the migrant workers and their families.

Healthcare in Central and South America has lagged behind that of the United States (Migrant Clinicians Network). In some countries, inadequate preventive and medical service is widespread. As a result, people from those communities are more likely to seek help in advanced disease stages (Migrant Clinician Network). Chronic medical conditions such as asthma, diabetes, hypertension, and parasitic infections may go untreated for long periods. This may lead to further complications and an advanced disease state, both of which result in increased treatment costs. When migrant workers come to the United States with unidentified latent disease states, the cost of treatment, both socially and economically, increases as the disease progresses (Migrant Clinicians Network).

Medical records in some cases are poorly maintained, lost to weather phenomena, fires, and vandalism (Migrant Clinician Network). Most medical services in Hispanic countries do not have electronic databases, telephone lines, fax machines, e-mails, interpreters, and other clerical means to maintain copies of medical records from the country of origin (Migrant Clinician Network). A second effect of migrant workers changing their names is that tracking and matching of medical records from country of origin and from prior medical care encounters in the United States is hard to maintain.

Existing Services

Community Health Centers

In the United States, there were almost 900 Community Health Centers (CHCs) in 2003, serving 23 million Americans (US Department of Health and Human Services,

1999). That accounts for about 4% of the total primary care of the total United States population, but 14% of those visits are by ethnic minorities and 28% of those visits by ethnic minorities have only Medicaid or no insurance (Forrest CB, Whelan E., 2000). About 74% of patients going to CHCs are uninsured or have Medicaid, as opposed to private medical practices that have 19% of uninsured or Medicaid patients (US Department of Health and Human Services, 1999). In North Carolina, the 23 CHCs that exist served about 260,000 patients in 2003, and approximately half of these patients had no medical insurance (North Carolina Department of Health and Human Services, 2003). In 2003, the racial profile of the population served by the CHCs in North Carolina was composed of 40% African American, 27% White, and 25% Hispanic (US Department of Health and Human Services, 2003).

The federal Migrant Health Program is part of the Department of Health and Human Services Bureau of Primary Health Care. This program was started in 1962 as part of the Migrant Health Act (Public Law 87-692) (USDHHS, Bureau of Primary Care). It provides grants for culturally and linguistically competent medical and support services to migrant workers and their families (USDHHS, Bureau of Primary Care). Community Health Centers are part of the Migrant Health Program. They are funded under section 330 of the Public Health Service Act (USDHHS, Bureau of Primary Care, 2002-7). By grant requirements, they must be located in medically underserved areas and provide primary medical care with translation and transportation services to promote access. Services must be available to all residents with fees adjusted based upon the ability to pay, be governed by a community board, and meet other financial, performance, and accountability requirements (USDHHS, Bureau of Primary Care, 2002-7).

The success of these CHCs is in part secondary to the inclusion of community boards, culturally-appropriate services, outreach, case management, eligibility assistance, partnership with other local health and faith organizations, and other health and human services located in one comprehensive system (Smith D. Alden, Money B., 2004).

Community Health Centers are required to serve in a medically underserved area as mandated by the Secretary of Health and Human Services (USDHHS, Bureau of Primary Care). Other centers that serve a designated MUA (medical underserved areas) or MUP (medical underprivileged areas) and meet criteria for Section 330 but are not funded through that venue are eligible to be certified as Federally Qualified Health Centers (FQHC) (USDHHS, Bureau of Primary Care). As such, they qualify to receive cost based reimbursement of services to Medicaid eligible, thus augmenting their billable services (USDHHS, Bureau of Primary Care).

A new federal initiative will provide Community Health Centers with more funds to expand services and add 6.1 million patients by 2006 (USDHHS, Bureau of Primary Care). The Expanded Medical Capacity Program will add 330 additional access points (USDHHS, Bureau of Primary Care).

In North Carolina, 23 different CHCs are under this program. Out of those, six clinics provide specific healthcare for migrant workers: Blue Ridge Community Health Services (Hendersonville), Gosher Medical Center (Faison), Greene County Health Center (Snow Hill), Kinston Community Health Center (Kinston), The North Carolina Farm worker Health Program (Elizabeth City, Sparta, Whiteville, Snow Hill, Spring Hope, Sylva, Prospect Hill, Maxton, Stovall, Dobson, Raleigh), and the Tri-County Community Health Council INC (Newton Grove). In 2001, the CHC clinics in North

Carolina served a total of 224,669 patients; 25% of these individuals were Latinos (North Carolina Institute of Medicine, 2003).

CHCs are equipped to provide primary healthcare to the patient population they serve. Some of them are also able to provide additional services, such as dental care, mental health, obstetric care, and enabling services (North Carolina Institute of Medicine, 2003). However, these clinics do not offer specialized medical services, such as surgical, eye, or orthopedic care (North Carolina Institute of Medicine, 2003). Some of them provide pharmacy, transportation, evening clinics, sexually transmitted disease diagnosis and treatment, mammogram services, and prenatal care (USDHHS, bureau of Primary Care). The federal grant covers from 20% to 40% of the total clinic costs (North Carolina Institute of Medicine, 2003). CHCs set their fee on a sliding scale based on local prevailing rates, for patients with incomes of 200% of Federal Poverty Guidelines and below (Smith D. Alden, Money B., 2004).

State clinics

The State of North Carolina, through the North Carolina Office of Research, Demonstrations and Rural Health Development, funds 31 health clinics located in rural North Carolina. As part of the funding conditions, they are obligated to treat uninsured patients on a sliding fee scale basis (North Carolina Office of Research, Demonstrations and Rural Health). This office provides incentives to medical and dental providers by identifying practice opportunities, assisting in contract review and negotiations, and assist providers in the form of loan repayment (North Carolina Office of Research, Demonstrations and Rural Health).

Local Health Departments

North Carolina Local Health Departments provide the same array of services to the Latino population that they provide to the general population. Services such as immunizations, sexually transmitted diseases treatment, family planning, prenatal care, and child health clinics are provided by most Local Health Departments (LHDs) (North Carolina Institute of Medicine, 2003). Only 11 percent of the Latino population in North Carolina received medical care at the Local Health Departments in 2001 (North Carolina Institute of Medicine). In addition, only 38 of the 100 LHDs in North Carolina provide comprehensive primary health care. None of the LHDs provide secondary or tertiary medical care (North Carolina Institute of Medicine). Moreover some LHDs lack translators, transportation facilities for patients, are inaccessible after working hours, and have a stigma in the Hispanic community of treating only children, women for contraception, or males for sexually transmitted diseases. The absence of specialized Latino clinics in LHDs is a sign of the difficulties in obtaining cultural competencies in otherwise busy Health Departments.

Free Clinics

There are over 50 free clinics in North Carolina (North Carolina Association of Free Clinics). They are community based organizations, with a volunteer base of providers, serving the uninsured, underinsured, and low income population. Most of the free clinics in the state are sponsored by religious organizations. They are mainly funded by grants and local donations. Some clinics provide medications to their patients (North Carolina Association of Free Clinics). One particular free clinic in Buncombe County is sponsored by the local medical society. It provides an extensive array of services, both

directly and indirectly, by referral (Smith J., 1997). Most of the other clinics do not provide comprehensive primary medical care or secondary medical care. The free clinics provide services to the Latino population in the same way that LHDs do through the same general services they provide to the rest of the community (North Carolina Association of Free Clinics).

Private and Charity Services

Some medical providers in North Carolina will provide occasional medical care to the Latino population. These efforts are highly appreciated by the Hispanic community. They are mainly unnoticed, unreported, and sporadic. In special circumstances, a religious organization will identify a Latino in need of medical care, and it will provide the funds to treat that specific person. The fact that this represents a small number of persons treated, it is still worth mentioning. This manner of compassionate care makes a difference in terms of community strengthening.

Emergency Departments

Based on a federal law known as EMTALA, Emergency Departments are obligated to provide medical screening and emergency services to patients that come into the Emergency Department, irrespective of their ability to pay for the services (USDHHS, EMTALA overview). The intent of the law is to provide emergency services to those people in need (USDHHS, EMTALA overview). The reality is that Emergency Departments around the United States are utilized as free clinics for primary care problems. The domino effect is that real emergencies may need to wait for those patients with perceived emergencies to be seen, and that the cost of medical services in the

Emergency Departments will increase for all users. Hospitals will pass on the cost of non-paying patients to the insured patients, thus elevating insurance premiums (USDHHS, OIG, 2001).

Migrant workers and their families are generally not covered by health insurance (Camarota S., Edwards J., 2000). Free clinics and Local Health Departments that may provide primary health services are usually closed by the time farm workers end their shift and can seek healthcare. The Emergency Departments become the default healthcare provider for this community to obtain its primary healthcare services. This stymies the mission of Emergency Departments as they are not intended to provide primary medical care. It also increases the cost of medical care because the cost associated with running an Emergency Department is higher than that of a medical clinic. In addition, the primary care provided at the Emergency Departments is incomplete and fractional due to a lack of adequate routine tests and nonexistent or haphazard follow up. Therefore, the inappropriate use of Emergency Departments for primary care increases the cost of medical care without significantly improving health services.

Unique Barriers to Healthcare for Migrant Workers

Immigration Status

Since the tragic incident on September 11, 2001, the appearance that immigration laws have been strongly enforced is evident. Multiple arrests in airports, on military installations, and other facilities have made the Hispanic community more reluctant to identify itself in public or to seek assistance or help from public safety officials. After the Patriot Act was established, it became harder for migrant workers to open bank accounts

(Woolford A., 2002). Consequently, they have resorted to keeping large amounts of cash at their houses, making themselves easy targets for criminals who take advantage of the fear Hispanics have of going to the police to report a crime (Woolford A., 2002).

The ability to stay in the United States for Hispanic migrant workers and their families depends mainly on their INS status. Immigration laws are under the purview of the federal government. Legal residency is advantageous as it provides migrant workers with rights and benefits reserved for citizens, such as the right to vote, the right to be part of a jury, the right to travel with a US passport, priority in bringing family to the US and obtaining US citizenship for their children who are born abroad, consideration for employment by the federal government for jobs, ability to be a candidate for electoral positions, different tax requirements than for naturalized citizens, maintaining legal residency, the ability to obtain student grants and loans, and the ability to obtain loans from the Federal government (US Citizenship and Immigration Services). The complexity of immigration laws, legal fees and expenses, general ignorance, and fear often times precludes migrant workers from applying for citizenship.

Language and Cultural Competencies

Basic language difference from Spanish to English is the most evident barrier for Hispanics to communicate, and therefore obtain healthcare in the United States. Some informal arrangements with lay people in the community may help to alleviate this communication deficit. However, privacy and confidentiality is challenged as those lay people live in the same community as the patients. Children of migrant workers that have attended schools in the US may help to translate for their parents as well, but again

confidentiality issues arise (Martinez N., Bazan-Manson A., 2004). Federal law requires that organizations and providers receiving federal funds not discriminate against people because of race, ethnicity, or national origin. This law, known as Title VI of the Civil Rights Act of 1964, has been interpreted by the federal government to insure that individuals have the right to receive services in a language they understand (Department of Justice. Civil Rights Division). At the present time, most institutions in North Carolina rely on a handful of hospital employees to translate for Hispanics or rely on translation telephone services (Martinez N., Bazan-Manson A., 2004). Those services are costly, impersonal, inconvenient, and tedious and may not accurately convey the exact nature of the medical problem.

Economics

Healthcare is costly. For families with an annual income of ten thousand dollars or less to pay for food, shelter, clothes, diapers, medications, and send money back to their families in their country of origin is unrealistic. Resources are vastly inadequate to make health prevention a significant priority to migrant workers. Given that most migrant workers and their families have no health insurance, the costs for visits to health facilities and the required treatment involved comes at the expense of reducing the amount used for other basic needs and obligations. Folk healers, advice from the elderly, and using unfinished medications from other family member seems a reasonable alternative under those circumstances, even if the remedy does not treat the problem or even worse, if the medication is contraindicated (Migrant Clinicians Network).

Prescription drugs are expensive as well. If the Hispanic population seeks help for a medical condition, and the medication is expensive, Hispanics may choose not to take medications, or to use only part of the prescribed treatment. Saving some medications for a future outbreak of a disease is a common practice, despite the possibility that the medications may be expired or that medications have been kept under poor storage conditions, and therefore affecting the efficacy. Sharing of medications is another common practice, regardless of whether or not an adequate medical evaluation and diagnosis have been made. In addition, programs from pharmaceutical companies that offer medications free or at a reduced price for qualifying patients are limited for non-citizen applicants (Patient Assistance Program Center). With the ban on imported medications from outside the US, opportunities for migrant workers to obtain medications, especially for chronic conditions, at a reduced fee are nonexistent.

Ancillary Services

In general, Hispanics have a low rate of obtaining routine preventive tests such as pap smears, mammograms, colonoscopies, lipid panels, and glucose screens (2000 National Health Interview Survey). Reasons for this are multiple. Cost of these preventive measures is considerable. The previous tests are inconvenient to obtain as they require time away from work. In addition, low health literacy levels may prevent compliance with routine preventive tests. However, CHCs have demonstrated better compliance with diagnostic tests, especially mammograms, in the Hispanic population at higher levels than the overall national levels (Based on 2002 Health Center User Survey).

Recommendations

Access to healthcare is a problem not solely limited to the migrant workers and their families. In fact, it is a national crisis affecting many minorities throughout the United States. Poverty, racial discrimination, poor understanding of health issues, substandard living conditions, and other socio-economic problems are contributing factors to lack of access to healthcare. In addition, migrant farm workers present with exclusive and unique cultural barriers to obtaining health care, including social factors, individual behaviors, cultural barriers, biological factors, environmental factors, potential bias among treating providers, public and private health policies, and differential access to healthcare services (Healthy People 2010).

Adequate Assessment

Limited data to adequately evaluate the status of the Hispanic healthcare is a major obstacle in generating adequate policies and allocating resources. Since most migrant workers come to the US illegally, there is no comprehensive census of this population, only estimates (Passel J., 2005). In addition, when migrant workers change their names for fear of prosecution, it makes individual identification inaccurate. The migratory nature of farm workers compounds the problem, as adequate follow up is near impossible. Lack of individual data in terms of race, ethnicity, socio-economic situation and measures of acculturation, such as language use, place of birth, and generational status, is not present in many programs, or if available, the information is collected in a non-standardized fashion. The Hispanic community of North Carolina is not localized in a single place, but rather it is dispersed throughout rural North Carolina, making the task

to visit and concentrate physical efforts in a particular area somewhat difficult. The National Research Council of the National Academies has recommended strengthening the information technology to obtain and track those measures (Vines A., Godley P., 2004).

An adequate model to follow for data compilation is the one from five CHCs in Eastern North Carolina. This model uses the same electronic medical records system which makes possible the sharing of data and compiles large sets of information for the region (Alden Smith D., Money B., 2004).

Work Within the Community

Improvement of the socio-economic status of Hispanics will improve the overall health of the members of this community. Health is a broad concept and is affected by multiple factors. By improving living and working conditions in facilitating adequate housing, running water, adequate septic systems, and access to healthy food choices will help to reduce gastrointestinal and parasitic infections. Ability to participate in driver's educational training, to legally obtain a driver's license, and to purchase a vehicle and insurance will improve access to a safe means of transportation, which will in turn decrease the incidence of trauma secondary to motor vehicle accidents to community members and the general public.

Efforts within the Hispanic community are slowly taking place to improve knowledge, communication skills, migratory status, and health among the community. Those efforts are coordinated by faith-based organizations, Local Health Departments, not for profit organizations, corporations, and private individuals. They include health

fairs, and health screenings for diabetes, cholesterol, elevated blood pressure, and dental problems. In addition, English as a second language classes are offered throughout North Carolina. Additionally, seminars for local fire and police officers include basic information about cultural differences for the Hispanic community. Moreover, some banking institutions offer advice in Spanish for potential clients. Hispanic media in North Carolina now includes local television channels and multiple radio stations that provide health advice to Hispanic listeners (Hispanic PR Wire).

Specialized Clinics

Expanding local health centers that provide primary medical care to a population that includes Hispanics will provide the local expertise in treating medical problems with the advantage of assisting this community in a culturally sensitive fashion. Community Health Centers have proven to be an adequate forum for migrant workers and their families to obtain primary medical care. Those centers have evolved to be culturally aware and sensitive to the needs of this community.

LHDs are also placed in an advantageous position to assume the role of primary care providers in North Carolina. The widespread location of LHDs puts them in a great position to reach the Hispanic community statewide. Most of the LHDs are located in urban centers away from the rural area, but local transportation should help resolve this situation. Resources from LHDs are multiple and include family planning, vaccination, STD clinics, smoking cessation, and others. In addition, facilities at LHDs include primary medical providers in the form of physicians or nurse practitioners. Contact with local secondary and tertiary medical care services, and sometimes the inclusion of a small

pharmacy are becoming more common. Services in LHDs may be easily modified to accommodate Spanish speaking clients. With appropriate educational materials, social workers can serve both as case managers and translators, expansion of service hours will accommodate farm workers, transportation services will facilitate visits to the clinic, and case workers with cultural competencies will follow these patients in the community. LHDs have the tools to understand the unique needs of the migrant workers, the cultural differences, the language barrier, and obtain cultural competencies to promote adequate healthcare to facilitate the timely delivery of medical treatment.

Health Insurance

Obtaining health insurance is clearly a significant barrier to obtaining primary healthcare. Establishing affordable health insurance for migrant workers by granting incentives to employers, by legislation, or by other means will improve access to primary healthcare, prescriptions, and secondary and tertiary medical care. Improving insurance coverage for farm accidents is also needed. Establishing migrant health insurance will not only help migrant workers and families to obtain healthcare, but will also provide hospitals and other facilities with some reimbursement for services rendered. In addition, as some of those costs are absorbed by the state Medicaid, the general population of North Carolina will benefit by reduced health insurance premiums.

In conclusion, lack of healthcare and health insurance for the nation's largest minority group, Latinos, has severely impacted the migrant worker population and has overtaxed Emergency Departments. There are several social and cultural barriers related to migrant worker health disparities. However, with the advent of specialized clinics that

understand the unique needs of the migrant worker population, their cultural, language barrier, and have cultural competencies, timely delivery of medical treatment prevails benefiting both the migrant worker community, the general population, and medical resources.

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