Justice in U.S. Health Care Policy and the Well-Being of Farmworkers

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Abstract

Farmworkers in the U.S. are systematically marginalized. They tend to live in isolated areas with limited access to health care centers and recreational facilities. The hardships of agricultural labor put the farmworker population at high risk for injury and disease. Infectious diseases such as tuberculosis, fungal infections and pesticide poisoning are common in this population. In addition, agriculture is a sector with one of the highest rates of fatal occupational injuries. However, traditionally, farmworkers have been unable to access health care. Understanding some of the structural barriers in place leads to the root of this injustice—oppressive policies that deny access to health care to a population with high health care needs. In this paper I use the theoretical framework "wellness as fairness" to illustrate the justice in U.S. health care policy and its relevance for the well-being of farmworkers.

Introduction[1]

From 2002 to 2011, 19.5 million temporary workers and their authorized relatives were admitted to the U.S.[2]Among this group, 836,294 were seasonal farmworkers admitted under the H-2A temporary-worker program.[3] These numbers are illustrative but not exhaustive, as many agricultural migrant workers in the U.S. are not affiliated with a temporary worker-program. An estimate points to about 1 million to 3 million farmworkers working in the U.S. every year.[4] In this paper, I offer an overview of the challenges faced by agricultural migrant workers, including issues of access to healthcare. The terms farmworker and agricultural migrant worker are used interchangeably. I employ a recently developed "wellness as fairness" theoretical framework[5] to examine issues of justice in U.S. health care policies for farmworkers.

Farmworkers as a Marginalized Group

For a number of years there have been concerns of the marginalization and exploitation of agricultural migrant workers. The 1940s and 50s witnessed the hardships faced by *Braceros,* farmworkers under a temporary-worker program, which lasted until 1964. Advocates systematically highlighted the numerous violations of workers' rights under the Bracero Program.[6] But even with recognizable violation of rights, temporary-worker programs continue.

The seasonal agricultural worker program (H-2A) operates today under certain labor standards, however, it is also known for unjust practices related to this form of admission: low wages, unacceptable working conditions and lack of a pathway to naturalization. [7]

Several reports[8] have indicated that typically, farmworkers live in isolated camps, away from healthcare centers and recreational facilities. They also refer to farmworkers' isolation, the continuous stress of having dependent family back home often leading to depression and anxiety, the numerous illnesses farmworkers suffer from, including tuberculosis and pesticide poisoning, and how the mobility of this population jeopardizes continuity of care.

Agriculture has been classified as a high-risk job in the U.S. In 2011, fatal occupational injuries for agriculture had a rate of 24.4 compared to considerable lower rates in other industries for that same year (e.g. 15.8 for mining and 8.9 for construction).[9] According to a report by the Kaiser Family Foundation (KFF), farmworkers have difficulties accessing healthcare services.[10] In 2009, 66% of farmworkers were uninsured[11] compared to 37% of low-income adults in the U.S. for 2010.[12] Table 1 summarizes some socio-demographic characteristics of this population, based on the National Agricultural Workers Survey (NAWS), conducted by the U.S. Department of Labor from 2007-2009.[13]

We can see that:

- The majority of farmworkers are from Mexico, followed by Central Americans.
- Nearly half of farmworkers are undocumented.
- The majority of farmworkers are men in highly productive age-brackets, the average being 36 years of age.
- Farmworkers have a limited English proficiency and low educational attainment.

Table 1: Basic Characteristics of Farmworkers in the U.S. (2007-2009)

Farmworkers			
Gender	Male 78%; Female 22%		
Average age	36		
U.S. Born	29%		
Foreign Born:	71%		
Mexico	68%		
Central America	3%		
Puerto Rico	1%		
Other	1%		
Current Legal Status:			
U.S. Citizen	33%		
Permanent-Resident	18%		
Undocumented	48%		
English Ability:		Speaking	Reading
Not at all		35%	45%
A little/Somewhat		35%	26%
Well		30%	29%
Highest Education Level:			
No School/1st-3rd	16%		
4th-7th	32%		
8th-11th	24%		
12th (graduated high school)	19%		
Some college	9%		

Sources: Carroll and Saltz, R. National Agricultural Workers Survey (NAWS) 2007-2009.

In my own fieldwork with farmworkers in Florida, I have witnessed farmworkers' efforts to retain a voice while enduring hardships in labor.[14] A farmworker once told me how she and her coworkers were sprayed with water by their supervisors while working. They went to defend themselves but then refrained from doing so "because if you do not have work you are nobody, you cannot pay your bills." It has been documented[15] that this feeling of invisibility compounded with a fear of authorities increases hesitation to report abuse and to reach out when in need of services.

Similarly, the limited English proficiency of farmworkers further limits their voice. As noted in Table 1, over a third of farmworkers report not speaking any English, and close to half

report not reading English at all. In fact, some farmworkers only speak indigenous languages with Spanish as a second language. The inability to effectively communicate hinders farmworkers' capability to access services.[16]

The marginalization of farmworkers is perpetuated by low educational attainment and poverty. In 2007-2009, the mean highest grade completed by agricultural migrant workers was estimated to be eighth grade.[17] Low education is related to farmworkers' low wages. The NAWS estimated that farmworkers earn a median family income between $17,500-$19,999 per year, which is below the poverty line of $23,050 for a family of four.[18] Moreover, according to Migrant Clinicians Network, a yearly annual income for a farmworker can be as low as $7,500.[19] Thus, farmworkers are subjected to poverty and food insecurity. The prevalence of food insecurity in farmworkers' households is four times higher than in the general population.[20] In my own fieldwork, reports of financial struggles were common. A middle-age farmworker once told me that even a full-time job did not secure a good income for her family: "they give me full time and is not enough and I wonder how am I going to feed my children." Nonetheless, economic inequality is just one part of a larger pattern of injustice. Farmworkers also have a worrisomely low life expectancy, which United Farm Workers reports to be about 49 years of age.[21] Table 2 compares farmworkers and other groups on this and other important characteristics.

The challenges for farmworkers, characterized by their historical marginalization, demonstrate how their well-being is at risk. Therefore, an understanding of current policies can provide insight into the promotion of justice to improve well-being.

Table 2: Comparison Characteristics between Farmworkers and other groups (2011)

	White Non-Hispanic	Hispanic	Black Non-Hispanic	Farmworker
Life Expectancy of males (1)	76.3	78.7	70.7	(4) 49
Percent Uninsured (2)	14%	32%	22%	(5) 66%
Median Family Income (3)	$55,412	$38,624	$32,229	(5) $17,500 - $19,999

Sources: CDC 2011; KFF 2011; NAWS 2007-2009, U.S. Census Bureau 2011, UFW 2006.
Notes: Data refers to 2011 with exception of (4) and (5). (1) Data from CDC, (2) Data from KFF, (3) Data from the U.S. Census Bureau, (4) refers to 2006 based on data from UFW, (5) refers to 2007-2009 based on data from NAWS.

Wellness as Fairness for Farmworkers

Arguably, the "wellness as fairness" approach by Prilleltensky (2012) is relevant for the analysis of farmworkers' experience with the healthcare system.[22] This framework provides a systematic process to examine the justice in U.S. health care policy, following the premise that access to healthcare is a critical component to achieve a positive well-being. First, an introduction to well-being will be presented, followed by a commentary on justice.

Well-Being

Prilleltensky (2012) labels well-being as "a positive state of affairs, brought about by the simultaneous and balanced satisfaction of diverse objective and subjective needs of individuals, relationships, organizations and communities."[23] The definition considers various levels of analysis (i.e. personal, interpersonal, organizational and communal). According to Prilleltensky,[24] each of these levels must support the following six "domains of wellness": economic, physical, occupational, psychological, community and interpersonal. The domains of wellness are areas that must be met to achieve well-being, and these take on different forms

based on the level of analysis. For instance, for the communal level, the six domains of wellness are referred to as: economic resources, health promotion, function, freedom, equality, and participation and inclusion. For each domain, Prilleltensky specifies objective indicators, referring to material needs that must be met for well-being to thrive.

In this paper, I examine the communal level of well-being based on Prilleltensky's argument that justice at this level is felt at all the other levels of well-being. Within the communal level, I analyze the health promotion domain using the corresponding objective indicators as defined by Prilleltensky.[25] Analyzing the health promotion domain will illustrate whether the healthcare conditions of farmworkers promote or hinder a positive communal level of well-being. Table 3 shows the health promotion domain with its corresponding objective indicators.

Table 3: Health Promotion Domain of the Communal Level of Well-Being

Level of Well-Being	Objective Indicators for Health Promotion
Communal	Access to high quality healthcare.
	Federal policies in place to promote healthy eating and physical activity.
	National prevention of epidemics and exposure to toxic substances.

Sources: Table adapted from Prilleltensky 2012.
Note: The original chart from Prilleltensky includes four levels. The above chart only includes the Communal level as applicable to the health promotion domain.

Justice

A type of justice includes "distributive justice"—"the fair and equitable allocation of burdens and privileges, rights and responsibilities, and pains and gains in society."[26] Distributive justice is critical for farmworkers, as they are receiving unequal pains and gains compared to the general U.S. population. Therefore, applying distributive justice through the "wellness as

fairness" framework illustrates what is due to farmworkers to promote their positive well-being. Conditions of injustice hinder wellness, which can be perpetuated by current laws.[27]

Health Care Policy

The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), enacted in 1996, replaced the Permanently Residing Under Color of Law (PRUCOL) doctrine.[28] Under PRUCOL, an immigrant's status was not considered to provide federal public benefits.[29] PRWORA, or "welfare-reform," changed immigrants' access to social services, including Medicaid and food assistance. The law bars immigrants from means-tested federal public benefits for five years since their entry into the country or until naturalization. [30] Given that three-fourths of farmworkers are foreign-born and about half are undocumented, PRWORA substantially limits farmworkers' access to healthcare. Moreover, the interaction of welfare-reform with immigration policy further maneuvered the public's anti-immigrant sentiment.[31]

Interaction of Immigration and Health Care Policy

The Illegal Immigration Reform and Immigrant Responsibility Act (IIRIRA) was ratified the same year as PRWORA, 1996. IIRIRA restrains an individual without citizenship or lawful immigration status from receiving public benefits including Social Security and higher education assistance.[32] IIRIRA interacts with PRWORA by demanding verification of immigration status to provide social services. Legislators claim that decreasing accessibility to public benefits deters migration into the U.S.[33] However, U.S. citizens are more likely than green-card holders and undocumented workers to use healthcare.[34] In addition, reasons for migrating are not dependent

on access to social services.[35] Thus, deterring immigrants from healthcare services is not an effective means to halt migration to the U.S.

Moreover, IRRIRA led to the so-called "public charge doctrine," the myth that an immigrant who uses public benefits becomes dependent on government assistance, deterring immigrants from using services they may be eligible for due to fear that their eligibility to naturalize may be affected.[36] According to the NAWS, in 2007-2009, 57% of farmworkers did not use any form of public assistance.[37] In synthesis, U.S. legislation interacts restricting farmworkers' healthcare access. Unfortunately, recent health care policy has not changed this issue.

The Affordable Care Act

In 2010, President Obama signed the Affordable Care Act (ACA), or "Obama Care." The ACA may positively impact some farmworkers if they are U.S. citizens or permanent residents through a Medicaid expansion and health insurance exchanges.[38] Nonetheless, undocumented farmworkers will not be covered. In addition, farmworkers may gain coverage through employer-sponsored insurance. Small growers may purchase coverage for their employees through insurance exchanges, yet affordability is questionable. On the other hand, large growers are more likely to afford health insurance. However, this falls on the growers to choose honest practices and offer coverage.[39]

The ACA may also impact farmworkers through the provision of federal grants for community health care centers including federally funded migrant health centers (MHCs).[40] However, in 2011, the National Advisory Council on Migrant Health reported that the ACA funding will run out in 2014-2015 and that it only covers 25% of the cost for undocumented

farmworkers.[41] This cost-coverage is relatively low considering about half of farmworkers are undocumented.[42] The Council also commented on other issues not addressed by the ACA including how fear of the "public charge doctrine" leads to underutilization of MHCs.[43] Therefore, even though the ACA expands coverage for low and middle-income families[44] and provides funding for MHCs, it does not effectively promote access to healthcare for farmworkers.

Justice in U.S. Policies

Health care policies create structural barriers that prevent meeting the healthcare needs of farmworkers. Table 4 provides an overview of the most prominent policies relevant to farmworkers and the effects these have on the communal level of well-being according to the "wellness as fairness" framework.

We can see that:

- PRWORA restricts farmworkers' access to healthcare and positions a public health disaster—denying healthcare services to a population that usually lives in tight spaces and has high rates of communicable diseases.
- IIRIRA hinders access to healthcare and promotes oppressive practices in the workplace by mediating fears of deportation.
- The ACA fails to promote access to healthcare, failing to address the underinsurance of farmworkers.
- Overall, the above policies do not meet the objective indicators of the health promotion domain for the communal level of well-being.

This analysis demonstrates the lack of distributive justice in U.S. health care policy as it is not conducive to a positive communal level of well-being for farmworkers. The legislation creates persisting conditions of injustice that prevent thriving. Therefore, farmworkers in the U.S. are not receiving a fair and equitable distribution of pains and gains in the area of healthcare.

Table 4: U.S. Legislation and the Communal Level of Well-Being

U.S. Policy	Date Enacted	Objective Indicator of Health Promotion	Effect on Communal Level of Well-Being for Farmworkers	Meets Objective Indicator(s)?
PRWORA	August 22,1996	Access to high quality healthcare	Denies access to healthcare by barring immigrants from means-tested federal public benefits for five years since entry into the country or until naturalization. Denies services to undocumented farmworkers and hinders quality by creating an anti-immigrant sentiment.	No
		Prevention of epidemics	Denies healthcare to a crowded population with high health risks increasing the possibility of an epidemic.	No
IIRIRA	September 30, 1996	Access to high quality healthcare	Denies access to social services for undocumented farmworkers or those who cannot prove "lawful" status	No
		Prevention of exposure to toxic substances	Fear of deportation prevents abuse such as pesticide poisoning.	No
ACA	March 23, 2010	Access to high quality healthcare	Leaves undocumented farmworkers without access to healthcare.	No

Sources: Broder 1998, INS 2000, Skocpol and Jacobs 2010, Field 2002.

Conclusion

Farmworkers in the U.S. are a historically marginalized population. The analysis of the most prominent U.S. health care policies demonstrated the systematic barriers farmworkers face in accessing healthcare. The application of the "wellness as fairness" framework served to illustrate that in order for farmworkers to achieve a positive well-being, systemic justice in health care policy is needed. Further studies could expand this analysis by examining additional levels of well-being and focusing on other areas where farmworkers are in need of justice.

Endnotes

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