How Immigration Status Constrains Households' Access to Health Care in Farmworker Communities

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Evidence from the New Pluralism Study 2001-2005

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Beneath the Veneer of Homogeneity in Rural America

- Diversity among communities with concentrations of immigrants throughout the rural U.S.--based on migration history and maturity of sending migration networks
- Just as importantly, diversity within each community—based on migration networks converging there, migrant flows over time, changing economic base
- Current presentation based on case study of Arvin in California's San Joaquin Valley—half century after classic 1946 study by Goldschmidt "As You Sow…" -at that point 12% foreign-born, two-thirds of them Mexican immigrants
- Arvin is one of six case studies in the New Pluralism project. Survey of 160 households—about a 7% sample of a community of about 12,000.
- More than 2.5 million unauthorized immigrants live in communities like Arvin with ongoing migration flows from traditional sending communities in Mexico and Guatemala and smaller populations from Asia and Africa.

Intersections of Legal and Literal Identity

- Native born households —less than one out of five (18%). Half of these are headed by Mexican-American 2nd or 3rd generation immigrants (mostly Tejanos settled out from long-haul migrant farmworker circuit 1950-1965).
- Fully legal immigrant households—half of town (50%)—all HH members are legal permanent residents, U.S. born, and/or naturalized citizens
- Mixed-status households —one out of five (19%)—nuclear families with legal HH head but unauthorized wife or child, extended family members
- Unauthorized households —one out of eight or so (13%)—everyone is unauthorized
- Overall, one out in three households in town has problems related to family members' eligibility for services conditioned on immigration status.

Immigrant/Native-Born Community Profile Through Different Lenses

Table 1- Origin and Immigration Status of Arvin HH Heads, Overall Population, and Minors: 2003			
Citizenship/Immigration Status	% of Heads of Household (N=160)	% of All Persons in HH's (N=676)	% of Minors 0-18 years of age (N=287)
U.S.-Born	**18%**	**40%**	**68%**
US-born—non-immigrant family	9%	7%	4%
US-born--2nd -3rd gen. immigrant	9%	33%	64%
Foreign-Born	**82%**	**60%**	**32%**
Naturalized Citizen	10%	5%	1%
Legal Permanent Resident	42%	28%	11%
PRUCOL/Qualified	4%	5%	7%
Unauthorized	26%	22%	13%

***Source**: New Pluralism, Arvin Community Survey, Q. 9 (Household Grid)*

Intersections of Past, Present, and Future

- While most heads of household (82%) are foreign-born, most minors are U.S.-born (68%). Only a small number of children have no relation to immigrant families.
- Policy responses targeted to sub-populations among immigrants will not adequately solve family health issues—in the mixed-status households many parents and some children (usually the oldest) have constrained access to health care
- Twice as many of the heads of household are unauthorized as children in the households(26% vs. 13%)
- What are the consequences of families with healthy children but where parents are injured or ill?
- And what are the future consequences of disparities among peers—the 13% of minors who are unauthorized?

Zooming In on Age-Related Disparities in Access to Health Care

Table 2- Unauthorized Immigrants by Age Group and as Proportion of Overall Community Population		
Age Group	*Unauthorized Immigrants as % of Age Group*	*Unauthorized Immigrants in Age Group as % of All*
5 or under	2.6%	0.3%
6-12 years old	12.7%	2.1%
13-18 years old	20.0%	2.9%
19-24 years old	49.3%	5.6%
25-34 years old	44.2%	5.7%
35-44 years old	20.7%	2.9%
45-64 years old	15.2%	2.4%
65+ years old	---	---

Mainstream Solutions Hold Little Promise for Agribusiness Factory Towns

Table 3—Unauthorized Male Workers in Arvin By Occupation/Industry Segment of Labor Force			
Age Group as % of male labor force	% of male workers in occupation/industry cluster Who lack legal status		
	Agricultural workers (n=147)	*Service Workers* (n=9)	*All other occupations Industry clusters* (n=32)
13-18 years old (7%)	80%	---	---
19-24 years old (19%)	70%	50%	---
25-34 years old (21%)	59%	100%	14%
35-44 years old (26%)	28%	---	10%
45+ years old (27%)	11%	---	---

Employment and Immigration Status: Dual Disadvantages

- Unauthorized immigrant workers are concentrated in agricultural employment (73% of all working men and women). Teen-age and young adult males have the worst access to health care programs requiring proof of status
- Only 17% of farmworkers have health insurance from their employers; this benefit is usually available only to the long-time core labor force (not the unauthorized migrantes)
- With a median annual income of $11,250, even sliding scale fee structures pose barriers to health care (especially since the workers with least stable work are the most recent arrivals)
- Migrantes from non-dominant village networks have least access to desirable worker and, at best, frayed social networks for support—especially in hard times

Household Immigration Status Interacts with Other Factors to Affect Health Care Access

Table 4–Household Size, Migration History, and Educational Attainment By Household Immigration Status			
HH Characteristics	*Household Immigration Status*		
	Fully-Legal	Mixed	Unauthorized
Mean # of persons in HH	4.8	5.9	4.2
Mean time in US for adults in HH	18 years	10 years	4 years
Mean age at immigration for adults in HH	21.6	33.1	26.6
% immigrants who came as child 0-12	29%	16%	23%
% immigrants who came as teenager 13-18	29%	34%	23%
Mean education for HH head	6.5	7.1	7.2

HH's with the Worst Problems Have the Least Resources to Navigate the System

- Unauthorized and mixed-status HH's have the least familiarity with US life
- Family members in unauthorized and mixed status HH's came to the US later in their lives
- The mixed-status households are larger—making the complexities of navigating the health care system more challenging since there are more people and usually more economic pressures
- While HH heads of the more recent unauthorized and mixed-status HH's have slightly more education than the earlier, older legal immigrants, the differences are slight.
- Lack of education and language interact to degrade quality of provider-patient communication—especially with indigenous-origin families (particularly women)

Finally There Are Communication Barriers

Table 5–Household Language Profiles by Immigration Status of Household			
Language Profile	*Household Immigration Status*		
	Fully-Legal	**Mixed**	**Unauthorized**
HH Preferred Language	80% Spanish, 16% English 3% Mixtec, 1% Arabic	88% Spanish, 9% English 2% Mixtec, 1% Arabic	98% Spanish 2% Mixtec
HH Proficiency in English	38% English-proficient 9% Limited English 15% A bit of English	15% English-proficient 19% Limited English 18% A bit of English	7% English-proficient 15% Limited English 7% A bit of English
Language Barrier w/in Household	16%	17%	4%

Conclusions and Implications

- Sound health policy analysis and planning will require attention to disparities in access to health care—within communities and within households
- More attention will need to be given to helping immigrants navigate the system. “Family health access counseling”, not simply case management will be needed
- Short-term: address the health needs of young unauthorized teenage farmworkers will be important investments for the future
- Short-term: address the health needs of young adult immigrants—beyond maternal child health—will be needed to move from “healthy kids” to “healthy families”.
- Long-term: a legalization program as part of comprehensive immigration reform should guarantee immediate (not delayed) access to federally-funded health care services