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Structural Characteristics of Migrant Farmworkers Reporting a Relationship with a Primary Care Physician

H. Virginia McCoy, PhD,

Professor, Department of Health Promotion & Disease Prevention, Robert Stempel College of Public Health and Social Work, Florida International University, Miami, Florida

Mark L. Williams, PhD,

Department Chair, Department of Health Policy and Management, Associate Dean, Academic and Student Affairs, Robert Stempel College of Public Health and Social Work, Florida International University, Miami, Florida

John S. Atkinson, DrPH, and

Center for Health Promotion & Prevention Research, University of Texas School of Public Health, Houston, Texas

Muni Rubens, MBBS, MPH

Doctoral Student and Research Assistant, Department of Health Promotion & Disease Prevention, Robert Stempel College of Public Health and Social Work, Florida International University, Miami, Florida

H. Virginia McCoy: mccoyn@fiu.edu; Mark L. Williams: mlwillia@fiu.edu; John S. Atkinson: john.s.atkinson@uth.tmc.edu; Muni Rubens: mrube001@fiu.edu

Introduction

Migrant farmworkers are vital part of agricultural industry in the United States, and yet one of the most underserved and marginalized populations in the country. Migrant farmworkers are disproportionately affected by many adverse health conditions, but access healthcare sparingly [1, 2]. The lack of health care utilization could be due to individual factors, like immigration status, education, language barriers, and migration patterns. However, structural and institutional factors, such as lack of transportation, culturally competent health care providers, and improper location of services are also likely to affect migrants' healthcare utilization [1, 3, 4]. Federal, State and local governments have taken many initiatives to improve access to care among migrant farmworkers. Federally funded programs, such as federally qualified health center (FQHC) programs, provide primary healthcare, but these programs face many individual, social and structural barriers in reaching the migrant farmworker community [5]. The solution to health care utilization among migrant

Corresponding Author: Muni Rubens, MBBS, MPH, Department of Health Promotion & Disease Prevention, Robert Stempel College of Public Health and Social Work, Florida International University, 11200 SW 8th Street, AHC 4 - 405, Miami, Florida 33199, Phone: 305-348-5938, Fax: 305-348-0506, mrube001@fiu.edu.

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farmworkers is complex, and it is important to add to the scant research on health care access as a way to improve healthy communities.

Methods

The participants for this study were drawn from a randomized community study of an HIV risk reduction intervention. Participants were migrant farmworkers, recruited from “camps” (trailer parks, dormitory-style housings, apartment buildings, motels, and neighborhoods of single/duplex housing) in the immediate and surrounding areas of farms in Immokalee, a rural agricultural area in southern Florida. Participants were Spanish and/or English speaking men and women aged 18 years or older with a history of unprotected vaginal, anal, or oral sex, and/or consumption of alcohol or other drug in the past three months, and able to understand and provide written informed consent. The migrant workers involved in the present study are a mix of migrant workers and seasonal workers. The study’s definition of migrant workers was conformed to the Public Health Services Act (1944) definition [6]. The Public Health Services Act states that migrant workers are those individuals who are employed in agricultural labor, either seasonal or migratory, and live in temporary housing [6]. The study criteria did not limit the definition of migrant workers to those who travel 75 miles or cross county lines to work as stated by the Public Health Services Act. For this study, access to healthcare was measured by asking whether the participants had a primary care physician.

IBM SPSS Statistics for Windows, Version 21.0 was used to analyze the data (Armonk, NY: IBM Corp.). Two participant groups were created for the analyses based on self-report those who had a primary care physician and those who did not. First, Chi-squared tests were used to test for differences between two groups. Then, multivariable logistic regression was done with presence of primary care physician as outcome and variables which were significant in bivariate analyses as independent variables to calculate adjusted odds ratio with 95% confidence intervals [7]. The independent variables in the model were age, gender, language, ethnicity, length of stay, salary, number of children, insurance status, HIV status and STD diagnosis. Length of stay included migrant farmworkers who lived in Immokalee for 5 years or less (newcomers) and those who lived for more than 5 years (long-timers).

Results

The sample was composed of African American (37.4%) and Hispanic (62.6%) participants and the majority (74.2%) reported that they didn’t have a primary care physician (Table 1). The mean age of the participants was 41.56 (SD = 12.39) years. Nearly three quarter were males and had less than a high school level of education. The majority of participants was single or lived as single (81.2%) and long-timers (70.9%). Nearly two third of participants had children and three quarter didn’t have insurance. Among the sample, 32 participants (7.4%) were diagnosed HIV positive and 102 participants (23.7%) reported a history of sexually transmitted diseases. Significant differences were found between participants who had a primary care physician and those who did not, on all demographic characteristics like age ($p<0.05$), gender ($p<0.001$), language ($p<0.001$), country of birth ($p<0.001$), ethnicity

($p < 0.001$), length of stay ($p < 0.001$), salary ($p < 0.01$), insurance status ($p < 0.001$), number of children ($p < 0.01$), HIV status ($p < 0.001$) and STD diagnosis ($p < 0.05$).

Multivariable logistic regression, using only factors having significant bivariate associations with having a primary care physician, showed that gender, insurance status, country of birth, and length of stay were associated with having a primary care physician (Table 1).

Discussion

Migrant farmworkers have substantial need to access health care because of the instability of their occupations and migrant status. This study found gender, length of stay, country of birth and insurance disparities in having a primary physician among migrant farmworkers. The major finding of this study was that the majority of participants did not have a primary care physician, our indicator of access. Female migrant farmworkers with insurance and who lived in Immokalee for more than 5 years were more likely to have a primary care physician than males, those without insurance and recent migrant farmworkers. That more women had a primary care physician could be due to increased rates of insurance coverage because the majority of them were in the child bearing ages. Similar to many other studies, in this sample of migrant farmworkers, having insurance was strongly associated with having a primary care physician [8]. However, it is important to note that gender is an independent factor influencing many population-based outcomes, including having a primary care physician and access to healthcare. Hence, in order to reduce the disparity between men and women in access to care, it is important to expand insurance coverage for men with low socioeconomic status. Another finding of this study is that, people who lived in Immokalee for more than 5 years were more likely to have a primary care physician. One plausible reason could be that migrant farmworkers living in the same place for longer times were more likely to be financially stable than those who migrated more recently. However, further studies need to explore the reasons for a greater proportion of long-timers and the influence of immigrant status on access to care among recently migrated farmworkers. The finding that participants who were born in the U.S. were more likely to have a primary care physician was in line with other studies [9, 10]. The study also found that a large proportion of people with HIV or other STDs did not have a primary care physician. This finding reiterates the importance of providing insurance to facilitate access to care for high risk populations like migrant farmworkers as this could lead to reduction of transmission of HIV and other STDs among migrant farmworkers and to the general population.

There are limitations to the study. The study did not specifically measure the reasons participants did not have a primary care physician or insurance. This measure could vary across gender and length of stay and could have better explained the variance in the outcome. Another limitation is the lack of information on the immigration status of the participants, which influences insurance status. A measure of insurance under-coverage or the length of time without insurance coverage would have been helpful in determining the influence of the probability of having a physician. The outcome variable of whether or not the participants had a primary care physician is only an indicator of access to health care. Findings from this study should not be generalized beyond the Immokalee drug and alcohol-

using migrant farmworker community. Finally, since this is a descriptive study, causality between various factors and having a primary care physician could not be inferred.

Conclusion

The United States is on the verge of a major expansion of health insurance to low-income individuals, which presumably will increase access to care. However, undocumented immigrants are barred from enrolling in Medicaid or receiving subsidies to purchase health insurance (and even documented immigrants are barred from enrolling in Medicaid until they have been in the US for five years). Also, Medicaid and exchanges will likely require documentation of income and residence, which could be a barrier for migrant farmworkers. This study demonstrates that more research is needed to document access to health care of migrant farmworkers. Unfortunately, the public health provisions of Affordable Care Act might not benefit this population. Hence more focus should be given to Community Health Centers and Migrant Health Centers in tailoring their services to the needs of migrant farmworkers. Gender, length of stay at a particular geographic location, and insurance status should be considered while prioritizing the services to improve having a primary care physician and access to care.

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Table 1

Characteristics of participants by having a primary care physician (N = 431)

Characteristics	Primary care physician 431 (100%)		χ^2	p-value	Total
	Yes 111 (25.8%)	No 320 (74.2%)			
<i>Age</i>					
18 to 34 years	26 (23.4%)	104 (32.5%)	8.448	<0.05	130 (30.2%)
35 to 49 years	45 (40.5%)	135 (42.2%)			180 (41.8%)
50 to 65 years	32 (28.8%)	73 (22.8%)			105 (24.4%)
65 years and more	8 (7.2%)	8 (2.5%)			16 (3.7%)
<i>Gender</i>					
Male	52 (46.8%)	260 (81.3%)	48.803	<0.001	312 (72.4%)
Female	59 (53.2%)	60 (13.9%)			119 (27.6%)
<i>Education</i>					
Less than high school	79 (71.8%)	244 (76.7%)	1.581	0.454	323 (75.5%)
High school	21 (19.1%)	55 (17.3%)			76 (17.8%)
Beyond high school	10 (9.1%)	19 (6.0%)			29 (6.8%)
<i>Marital status</i>					
Single/Living as single	94 (84.7%)	256 (80.0%)	1.185	0.276	350 (81.2%)
Married/Living as married	17 (15.3%)	64 (20.0%)			81 (18.8%)
<i>Language</i>					
Spanish	33 (30.0%)	183 (57.4%)	24.505	<0.001	213 (49.7%)
English	77 (70.0%)	136 (42.6%)			216 (50.3%)
<i>Country</i>					
Outside USA	11 (9.9%)	156 (48.8%)	52.383	<0.001	167 (38.7%)
USA	100 (90.1%)	164 (51.3%)			264 (61.3%)
<i>Ethnicity</i>					
African American	61 (55.0%)	100 (31.3%)	19.790	<0.001	161 (37.4%)
Hispanic	50 (45.0%)	220 (68.8%)			270 (62.6%)
<i>Length of stay</i>					
Newcomer	11 (9.9%)	114 (35.8%)	26.812	<0.001	125 (29.1%)
Long-timer	100 (90.1%)	204 (64.2%)			304 (70.9%)

Characteristics	Primary care physician 431 (100%)		χ^2	p-value	Total
	Yes 111 (25.8%)	No 320 (74.2%)			
Salary					
<\$199	25 (24.3%)	78 (26.9%)	11.909	<0.01	103 (26.2%)
\$200-\$399	22 (21.4%)	107 (36.9%)			129 (32.8%)
>\$400	56 (54.4%)	105 (26.7%)			161 (41.0%)
Children					
Yes	87 (78.4%)	202 (63.1%)	8.680	<0.01	142 (32.9%)
No	24 (21.6%)	118 (36.9%)			289 (67.1%)
Insurance					
Yes	65 (58.6%)	38 (11.9%)	98.757	<0.001	103 (23.9%)
No	46 (41.4%)	282 (88.1%)			328 (76.1%)
HIV status					
Positive	19 (17.1%)	13 (4.1%)	20.434	<0.001	32 (7.4%)
Negative	92 (82.9%)	307 (95.9%)			399 (92.6%)
STD diagnosis					
Yes	35 (31.5%)	67 (20.9%)	5.120	<0.05	102 (23.7%)
No	76 (68.5%)	253 (79.1%)			329 (76.3%)

Table 2

Association between participant characteristics and having a primary care physician

Characteristics	Adjusted Odds Ratio [†] (95% CI)	p-value
Age		
18 to 34 years	Ref	
35 to 49 years	1.755 (0.847–3.551)	0.343
50 to 65 years	2.736 (0.739–4.425)	0.124
65 years and more	1.028 (0.823–4.883)	0.873
Gender [*]		
Male	Ref	
Female	2.823 (1.575–4.103)	0.032
Length of stay [*]		
Newcomer	Ref	
Long-timer	2.728 (1.936–7.837)	0.021
Salary		
<\$199	Ref	
\$200–\$399	0.945 (0.536–1.624)	0.734
\$400	2.846 (0.856–2.736)	0.835
Language		
Spanish	Ref	
English	1.846 (0.846–2.983)	0.932
Country ^{**}		
Outside USA	Ref	
USA	2.648 (1.373–3.338)	0.002
Ethnicity		
African American	Ref	
Hispanic	2.845 (0.836–4.856)	0.845
Children		
Yes	Ref	
No	1.314 (0.738–3.985)	0.164
Insurance ^{***}		
No	Ref	
Yes	6.183 (4.956–11.937)	0.000

* p<0.05

** p<0.01

*** p<0.001

[†] Adjusted odds ratio compared with the reference group (Ref) in a logistic regression model with 95% confidence interval.

Note: Newcomers migrant farmworkers who lived in Immokalee for 5 years of less; long-timers those who lived for more than 5 years (long-timers).