Monograph series

Migrant Health Issues

Disaster Relief

by

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Monograph no. 7

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Migrant and community health centers (M/CHCs) are faced with great challenges in serving the farmworker population. They serve approximately 15% to 20% of the estimated 3,000,000 to 5,000,000 farmworkers nationwide. When faced with a natural disaster, these entities find themselves restricted by emergency relief vehicles that are financially limited and unable to respond to the needs of the areas that they serve. One of the criticisms of the emergency relief vehicles is that funding available on the Federal level is not appropriated to specific states. In addition, there is a cap to monies available to states under one major emergency relief program. In order to improve disaster relief in remote areas with limited resources, it is imperative that health centers become actively engaged in advocacy to secure a portion of the state allocation to assist with the additional costs, keeping in mind that, if successful, funding will be secured most likely a year or more after the initial disaster.

Although not well documented in the literature, there is anecdotal information indicating that several states that have experienced disasters have negotiated support for increased costs in health care delivery. These include Dade County, Florida after Hurricane Andrew; North Carolina in the aftermath of Hurricane Floyd; and California after the freeze of 1998. The California freeze experience is the most recent and includes the most far-reaching beneficial impact. This experience illustrates how health centers experienced extraordinary costs and some increased those extraordinary costs, through their participation in relief efforts. For the future, it is critical that the disaster itself be thoroughly documented, as well as any efforts and successes in bringing relief resources to bear on the health care system. Only through thorough documentation of the impact of such natural disasters on the farmworker population can we present the case for the need, and begin to effect relief on a more regular basis.

California Example

Mid-December 1998 brought the coldest temperatures to California in almost a decade. These temperatures were cold enough to devastate California's agricultural industry in eight counties. Emergency relief was immediately available for some sectors of California's agricultural areas. However, migrant health centers were not among those fortunate enough to have their losses addressed expeditiously. In July 2000, these centers finally received compensation for the losses incurred because of their emergency relief efforts.

Suspending the sliding fee scale resulting in 15,000 uncompensated encounters. Coordinating emergency food and clothing services and augmenting services supported by the Woman, Infants, and Children (WIC) program were just a few of the emergency relief efforts spearheaded by California's migrant health centers. Clinics chose to participate in disaster relief efforts because of their commitment to the health and well-being of the migrant and seasonal farmworker population. The provision of this care constituted extraordinary expenses, amounting to over $3 million (California Department of Health Services, personal Communication, March 7, 2000). Health centers that were able to bear the extraordinary costs implemented relief efforts.

After tremendous advocacy on the part of migrant health centers in freeze-impacted areas, California's Department of Health Services, the California Primary

Care Association and others, the California Office of Emergency Services distributed $1 million in Federal Emergency Management Agency relief funds to impacted migrant health centers (California Department of Health Services, personal communication, March 7, 2000). Migrant health centers received notice of the availability of funds in February of 2000, more than a year after the Freeze of December 1998.

This background document is intended to assist health centers that experience similar emergencies in seeking emergency relief for themselves and their low-income patients. Recommendations on changes that would assist health centers in securing this funding will also be provided.

Background

Mid-December 1998 brought five nights of freezing temperatures to California's Central Valley, the coldest temperatures since 1990. These temperatures devastated the Central Valley's citrus belt causing damage to the local economy in the amount of $370 million – in crop losses alone (Visalia Times Delta, 1998). However, the greatest victims of the freeze were those who have the least, the migrant and seasonal farmworker population and other working poor that depend on the citrus harvest for their livelihood. These vulnerable populations lost an estimated $42 million in lost wages for 5 ½ months of unemployment (Visalia Times Delta, 1999). The loss of employment created a dangerous public health situation. Disasters like the Central Valley freeze threaten the health of the most medically vulnerable populations, such as the migrant and seasonal worker population and their dependents.

Estimates indicate that 14,000 migrant and seasonal workers lost their employment due to the freeze (Visalia Times Delta, 1998). The last freeze in 1990 resulted in 15,000 workers losing their jobs (The Portville Recorder, 1998). The loss of these jobs impacted an estimated 60,000 people in all, most of whom were children of migrant and seasonal workers (The Portville Recorder, 1998). The loss of a source of income for a population that already survives below the poverty line means that they must focus on ensuring the bare necessities for their families. In this context, accessing health care services – even on a sliding fee scale – may be out of reach for most disaster victims.

Farmworkers are already more susceptible to preventable illnesses than the average population. Farmworkers often live in substandard housing with poor water quality and are often exposed to dangerous chemicals in their homes and their work site. The farmworker population's quality of life results in a high incidence of urinary tract infections, lead poisoning, and other preventable diseases (National Center for Farmworker Health, Inc.). According to the National Center on Farmworker Health, the migrant farmworker population suffers as much as twenty times the rate of diarrhea among the urban poor, and up to 78 percent of all farmworkers suffer from parasitic infection, compared to two or three percent of the general population. To a large extent, the freeze made this susceptible population lose their economic ability to access care.

Emergency Relief for Farmworkers

The Food, Agriculture, Conservation, and Trade Act of 1990 (42 U.S.C. 5177a)

In 1990, after a series of natural disasters in agricultural sectors, including California's 1990 freeze, the Food, Agriculture, Conservation, and Trade Act of 1990 (the Act) was passed. The Act allocated funding to the United States Department of Agriculture (USDA) for distribution to tax-exempt public agencies or private organizations that have experience in providing emergency services to low-income migrant and seasonal farmworkers.

In 1999, after California's freeze and another agricultural disaster in Florida, $20 million was appropriated to the USDA under the Act. Again the emergency funds were to assist low-income migrant and seasonal farmworkers under section 2281 of the Act. The Request for Proposals for Grants for Emergency Assistance to Low Income Migrant and Seasonal Farmworkers, which appeared in the Federal Register August 2, 1999, reiterated the intent of the funds. Public agencies or private nonprofit organizations with farmworker emergency relief experience were invited to apply for funds. The funds were to provide services to farmworkers, including assistance in meeting rent or mortgage payments, utility bills, child care,

transportation, school supplies, food, repair or rehabilitation of farmworker housing, and other services.

The majority of California's funding went to the United Farm Workers (UFW) to provide job training services. One health center was able to secure USDA emergency relief funding. That health center was in the highest freeze-impacted area and had strong impact documentation. For California migrant health centers, securing USDA emergency relief was difficult for many reasons. The presence of a historically powerful farmworker organization made efforts to focus relief funding on health a challenge. In addition, the types of relief services listed in the Act do not specifically include health. This oversight in the legislation makes securing health care funds more difficult. However, one migrant health center was able to secure funding through this vehicle.

The Food, Agriculture, Conservation, and Trade Act of 1990 provides a logical vehicle for migrant health centers to receive emergency relief. The addition of health care services to the language of this Act would facilitate the ability of health centers to access these resources.

Federal Emergency Management Agency and other efforts to Secure Emergency Relief Funding (FEMA)

In 1998-99, California's migrant health centers spearheaded a multitude of efforts to secure funding for losses suffered because of the freeze. We attempted to secure funding via our State's own budgetary process, while at the same time seeking compensation for losses under both FEMA and the USDA. Emergency relief was a new arena for California Primary Care Association (CPCA) and the migrant health centers we represent. Without any experience in this area, we followed all logical steps and sought out any allies**.**

The Importance of Documentation

As mentioned, in 1990 California experienced a similar freeze. Because of the presence of a strong farmworker advocate in the San Francisco office of HRSA, Manuel deSantiago, a study was commissioned to look at the impact of the freeze on migrant health centers. The study documented many adverse trends experienced by migrant health centers in the 1990 freeze, such as the dramatic growth in non-farmworker patients for migrant and community health centers, as well as the transition of previously insured packing-house farmworkers to uninsured status. The 1990 freeze resulted in a 17% increase in patients seeking health care services in migrant health centers. Many of these patients had lost their private insurance coverage, and therefore were seeking services under a sliding fee scale or self-pay system (Campos Communications, 1992).

Migrant health centers experienced a significant overall decline in collections of self-pay charges during the 1990 freeze because farmworkers lost the ability to even pay nominal sliding-fee-scale charges. The percentage of collection of self-pay charges decreased from 43% to 24% for the migrant health centers in the most affected areas. In 1990, losses were minimally estimated at $234,742 for each center studied (Campos Communications, 1992). A significant loss of revenue within a short period of time caused serious destabilization of the centers in freeze areas, jeopardizing their ability to serve all patients, including freeze victims.

The documentation of the harms to migrant health centers and the fact that California was experiencing the exact same natural disaster bolstered our advocacy on behalf of migrant health centers. In addition, this previous documentation provided us with information on how to document losses the migrant health centers were experiencing in 1998-99. HRSA again assisted in our efforts in 1998-1999 by documenting some of the costs to migrant health centers (de Santiago, 1999).

Mobilizing Allies

As mentioned above, HRSA played an important role in assisting California's migrant health centers. Other allies were just as critical, including Central Valley legislators and representatives and California's Department of Health Services (DHS). One legislator in particular, Assembly member Dean Florez, assisted our health centers throughout the entire process. He helped pressure DHS to seek the funding from FEMA and the USDA after our state-specific efforts had failed.

Conclusions

California's experience with two natural agricultural disasters has highlighted the tremendous difficulties migrant health centers face in serving an already medically vulnerable population. Currently, California's migrant and community health centers serve over 300,000 farmworkers and their dependents (OSHPD 1999). Without the additional hardships of a natural disaster, serving this population necessitates targeted outreach, enabling services such as transportation and interpretation, weekend hours, etc. The costs of serving this population are in many ways already extraordinary. Add to this situation a natural disaster, and most migrant health centers simply do not have the additional resources to adequately address these difficult circumstances.

Unfortunately, Federal assistance becomes available only if and when the President declares a disaster. Existing emergency relief vehicles are also seriously deficient at USDA because of the cap of $20 million that is imposed on farmworker disaster assistance. As California's experience illustrates, all health centers experienced extraordinary costs through their participation in relief efforts. Based on this experience, the Bureau should develop and implement an emergency relief plan for all health centers experiencing difficulties in serving victims of natural disasters.

Produced for the National Advisory Council on Migrant Health by the National Center For Farmworker Health, Inc., Buda, TX, October 2001.

Copies may be obtained through the following sources:

National Center for Farmworker Health, Inc., Buda TX
Phone: (512) 312-2700
http://www.ncfh.org

Migrant Health Branch, Bethesada, MD
Bureau of Primary Health Care
Phone: (301) 594-4300
http://bphc.hrsa.gov/migrant/

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