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Is California Really Covered?: The Inequities of Healthcare for Farmworkers

Introduction

California is a high yielding agricultural state with rich land ideal for farming. California is also home to a group of very hardworking citizens who labor the agricultural lands; farmworkers. A very large part of California's economy comes from agriculture, meaning that there is a very large population of farmworkers in the state. According to *La Cooperativa* (2023), there are between 500,000 to 800,000 farmworkers who reside in California. However, this group of individuals experience many insecurities when it comes to healthcare. There are many obstacles that these individuals face including lack of insurance, low socioeconomic status, fear of job loss, citizenship status, and rurality.

Based on my research, a big part of the problem that farmworkers face related to inequities in healthcare is the rurality of the areas in which they live and work. As a result my research question is: Does the rurality of a county inhibit insured California farmworkers from seeking healthcare? I think that part of the reason farmworkers do not or can not seek healthcare is because they live in rural areas in which the capacity for healthcare is insufficient.

In this paper I will explain the inequities that California farmworkers face in relation to healthcare. Our farmworkers work in very dangerous environments and are susceptible to adverse consequences. California benefits a great deal from agricultural laborers, so it is crucial to ensure that our laborers are healthy and cared for. I will then explain the theory and analysis that I have developed to assess my research question of whether rurality affects the rates of healthcare use for farmworkers. I will propose a hypothesis and explain my research design and the data that I collected. Finally, I will give an analysis of my results and what the potential implications of my results are.

Significance of Issue and Background

Working in agriculture is a very dangerous and hazardous occupation. Those who work in agriculture are the portion of the population who are at the highest risk of injury and illness because their jobs entail many hazards. These include heat illness, physical injuries, chronic diseases, etc (Cha and Barton, 2022). While there are so many hazards in field work, farmworkers struggle to get healthcare for various reasons including, low income, fear of job loss, lack of insurance and rurality (Soto et al. 2022). California is recognized as the largest producer of agricultural goods by value in the country, which would not be possible without the individuals laboring the agricultural fields (Rogers and Buttice, 2013). Farmworkers are responsible for the vast majority of this production yet face numerous disadvantages and barriers to healthcare. Revenue from agriculture as a result of farmworker labor cannot be sustained if the health of the workers is not sustained concurrently.

California's agricultural workforce is diverse. There are many men and women of various ethnic and racial backgrounds who work in the California agricultural fields. However, the most common characteristics of farmworkers are latino men between the ages of 25 and 44 who are of low socioeconomic status and typically have low education attainment (Rogers and Buttice, 2013). Many of California's farmworkers are also migrants who have either come to the country as undocumented laborers, or have migrated from a different part of the U.S following seasonal work (Lou and Escalante, 2017). Additionally, many of these individuals are of latino background, many do not speak english and find it difficult to communicate as a result of the language barrier.

Farmworkers are defined as individuals whose main source of income is earned through either permanent or seasonal labor in agriculture. It is reported that in a typical farmworker household there are high rates of poverty in which these individuals live in very poor housing. This group of people experience high rates of overcrowding and many farmworkers are not homeowners. Our farmworkers are an essential part of California's agricultural economy, however they are living in some of the most poor and impoverished conditions (California Department of Housing and Community Development, 2023). Furthermore, it is not just the farmworkers who labor the fields that are experiencing these living conditions, many of the farmworker population have families. *La Cooperativa* reports that about 63% of California farmworkers are married and about 58% have children. So, women and children are also living in poor living conditions with limited access to healthcare as the result of barriers like cost, internalized fears, and lack of insurance.

A big problem with having access to healthcare is the combination of cost and lack of insurance. In one evaluation of insurance coverage data of California farmworkers, it was reported that only about 37% of the farmworker population had health insurance (Rogers and Buttice, 2013). A majority of the farmworker population does not have health insurance for a variety of reasons including cost and lack of documentation. It is reported that undocumented farmworkers are 3% less likely to use healthcare in the U.S than documented farmworkers (Rogers and Buttice, 2013). Regardless, farmworkers experience disparities in healthcare which could lead to serious public health issues (Lou and Escalante, 2017). Furthermore, health insurance has a statistically significant impact on whether or not healthcare services are used (Hoerster et al, 2011). If an individual has health insurance, they are more likely to seek out services than those who do not have health insurance. Part of the problem is that in the

farmworker industry, a majority of the time employers do not provide health insurance to their employees.

The Affordable Care Act (ACA), which was passed in 2010 expanded Medi-Cal public health insurance to most low-income adults. It mandates that companies who employ at least 50 full-time workers to provide health insurance since the cost of health insurance is a large barrier to many people (Cha and Barton, 2022). A major implication that arises with farm labor was highlighted in a study by Lou and Escalante (2017), in which farm labor allows for seasonal employment. This means that many of California's farmworkers do not have access to full time employment status because they are seasonal workers. In turn, this means that because there is no full time employment status then a company does not have to provide the employees health insurance, leaving many farmworkers uninsured, further instanting the barrier to healthcare access.

Access to healthcare is a large factor to ensuring that the farmworker population is healthy. Labor in agriculture is one of the most dangerous occupations, so ensuring that farmworkers are getting healthcare to prevent and treat things like heat illness, skin disorders, respiratory illness, occupational injuries and overall general health and well being is very important to ensuring that the labor continues on. A study using the National Agricultural Workers Survey or NAWS evaluated the use of healthcare services for farmworkers. Of the research sample that was used more than half reported to have used U.S health care in the previous two years. It was discovered that there was an increase in use in association with the farmworkers evaluated being female, married, non-hispanic, U.S born, with a chronic disease and owning a vehicle (Hoerster et al, 2011). The characteristics associated with higher report of use are not in alignment with the characteristics of the average farmworker in California in

which we typically see male, latino, married, not U.S born individuals. Furthermore a correlation between health care and higher density population areas was discovered, meaning that healthcare was used more in more populated, less rural areas. Following this line it was also found that those who owned a car or had some access to transportation were more likely to seek healthcare (Hoerster et al, 2011). Again, this is not a characteristic of an average farmworker. The typical farmworker in California lives and works in rural areas in which transportation becomes a huge barrier to get access to healthcare. A study done by Soto et al 2022, found that accessing healthcare was difficult on two main factors, expense and distance. Healthcare was most frequently reported to be too far away or too expensive.

My research will focus mainly on the barrier that the rurality of an agricultural area creates. Farmworkers tend to live and work in rural areas, meaning that they are further away from healthcare facilities. Being in a rural area creates the problem of access, this problem is highlighted in Jones et al (2009) article for the USDA in which it restates that access is the “number one rural health priority identified by the rural healthy people 2010.” Hospitals in rural areas may have a limited capacity for reasons related to simply being in a rural area, insufficient staff, and insufficient funding. A hospital in Madera, California closed because it was in a rural, low income area and left thousands of residents without access to hospital services (Klein 2023). Additionally, hospitals in rural areas tend to be smaller and can only offer a limited range of services which means that there is a large amount of reliance on referrals to bigger hospitals, once again creating a barrier of distance and transportation for farmworkers in these areas. Transportation and travel times affect the frequency of which people receive medical care (Jones et al, 2009). A farmworker who has to figure out how to get to the next town over to get some medical care would potentially face some negative consequences.

Theory and Argument

A large reason for the inequities in healthcare for farmworkers is that many of the farmworker population live and reside in rural areas where the healthcare capacity may not be sufficient enough. The number of facilities may hinder the capacity of healthcare in rural areas meaning that they are not sufficient enough to treat the population around them. I hypothesized that more rural counties will have fewer healthcare resources for residents than more urban counties. To test this hypothesis I used the independent variable of rurality by percentage for 57 of the 58 counties in California. San Francisco county was excluded from the data collected as it does not have a rural area. Using rurality of each county I was able to evaluate if there was a relationship with the hospital facility number per 100,000 which was a dependent variable.

Another reason for healthcare inequities of the farmworker population could be the lack of insurance coverage. If one does not have health insurance, the cost of healthcare may hinder a person from seeking medical services (Hoerster et al, 2011). With this in mind, people in more rural areas may not have health insurance coverage, so I hypothesize that residents of more rural counties will seek healthcare less often than residents of more urban counties and more rural counties will have a larger uninsured population. To evaluate this hypothesis I will use the independent variable of rurality of a county by percentage compared to the health insurance coverage status of the population in each county by percentage. Typically, it is more likely for a person to seek healthcare if they have health insurance as compared to those who do not have health insurance (Hoerster et al, 2011).

A potential reason for why rural areas are not well equipped with healthcare facilities is because of the location (Bucklew, 2023). Furthermore, it is becoming increasingly more challenging to maintain a hospital in a rural area open (Foutz, Artiga, and Garfield 2017). The

reason for this is because of lack of funding, and lack of workforce. There is not enough funding to be able to establish a facility to treat patients who come into the hospitals in rural areas.

Pharmaceutical costs are also rising in general, and ensuring that rural areas are stocked with the proper materials to treat patients might not be a priority (Bucklew, 2023). Additionally, staff retention and recruitment is a problem. Medical professionals might not want to work in rural areas in which they would have to commute themselves to far distances.

An alternative explanation for healthcare inequities affecting the farmworker population may be immigration status. Many times immigration status is a large barrier for farmworkers. About 90% of farmworkers are undocumented (Cha and Collins, 2022). Documentation status leads to fears in the undocumented farmworker communities as well as the undocumented community overall. The fear of deportation is a large factor that can lead the undocumented population to refrain from applying to governmental aid programs like Medi-cal because they are worried about personal information being passed along to immigration officials, and fear that aid would jeopardize citizenship eligibility (Boyd-Barrett, 2018). Fear of deportation also results in immigrant families to avoid seeking healthcare consistently, and only see a doctor when absolutely necessary (Boyd-Barrett, 2018). Thus, documentation status is an alternative reason for farmworker health care inequities.

Research Design and Data

I tested two different hypotheses related to the capacity of healthcare in rural areas. Farmworkers tend to live and work in rural areas, so evaluating the healthcare capacity in those areas was relevant to my hypotheses. The first hypothesis was that more rural counties will have fewer healthcare resources for residents than more urban counties. To evaluate this hypothesis I used the independent variable of rurality per county by percentage, and the dependent variable of

the number of hospitals in each county per 100,000 people. The second hypothesis is that residents of more rural counties will seek healthcare less often than residents of more urban counties. To evaluate this hypothesis I used the relationship between rurality per county by percentage and percentage of the population that was uninsured and insured per county.

This study was a large-n, quantitative study. I began by searching the Census Bureau for data on rurality per county in California. I collected the rurality data for all 58 counties in California for the year 2020. Once I had the data, I ensured to compute it to percentage form. I chose to use data from 2020 because it is the most recent data that was available and I wanted to be able to run a study on information that was as current as possible. Additionally, data from 2020 would not be skewed by post-pandemic effects. Figure 1 below shows the distribution of rurality by county in California. A darker shade indicates a more populated county meaning it's more urban and a lighter shade indicates a less populated county meaning it's more rural. In the data that I utilized for my research, I ultimately excluded San Francisco county as it had a 0% rural population and was irrelevant for my research.

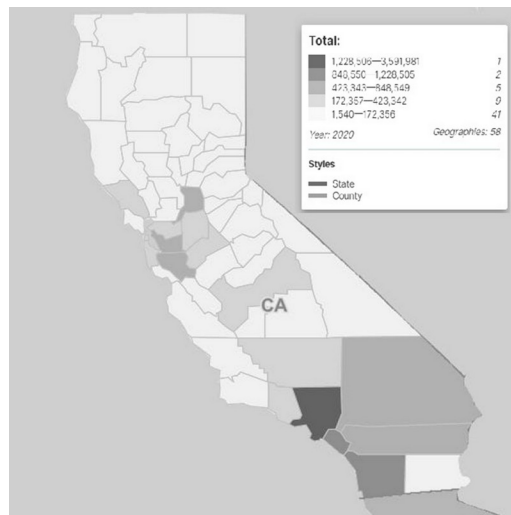


Figure 1: Map of rurality of each California County (Source: Census Bureau 2020)

To collect data on the number of hospitals per county, I used data from the California Health and Human Services from 2020. I compiled the number of hospitals per county onto a spreadsheet and computed the data to determine how many hospitals per 100,000 people there were per county. This helped me to understand the capacity of hospital facilities in each county.

To collect data on insurance status I used Census Bureau data from 2020 for all counties that reported the populations that were insured and uninsured. 42 of the 58 counties in California reported insurance status data. I used 41 of the counties as San Francisco did not have a rural population thus being irrelevant for my research. Each county had data numbers for the insured population and the uninsured population in age groups of under 6 to age 75 and older. Farmworker ages range from 16 to 65 and over (Rogers and Buttice, 2013). With this in mind, I decided to use insurance status data for the ages between 19 and 74 as it was the most representative of the age groups of farmworkers I found in my research. I organized the data into an insured column for each county of the population between the ages of 19 and 74 by percentage and an uninsured column for each county of the population between the ages of 19 and 74 by percentage.

Once I collected my data and computed it to all be in percentage form I created a scatterplot to analyze the relationship between rurality of counties by percentage and the number of hospitals per 100,000 people. The hospital number variable represented the healthcare resources evaluation part of my hypothesis. Furthermore, I used the number of hospitals in each county to account for the distance portion of my research question. I assumed that if there were a limited number of hospitals in a county, then an individual might have to travel further distances to get to a hospital. Traveling long distances to obtain medical care is a barrier that I could not measure directly, so assuming that lower numbers of hospitals in an area helped me to

operationalize the variable to something that I could analyze. Based on the scatterplot graph in figure 2, as rurality percentage increases, the number of hospitals also increases.

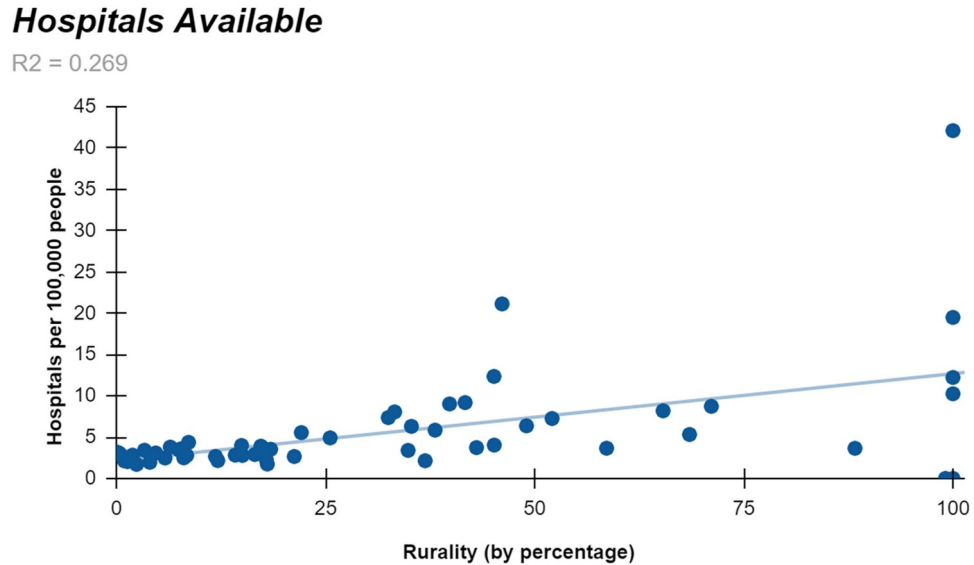


Figure 2: Relationship between rurality and hospital number

Once I collected all the data on insurance status of the counties that reported and computed the data to percentage form, I made two more scatter plots to analyze the relationship between rurality and insurance status. Cost is a barrier that inhibits individuals from seeking healthcare, and insurance is a factor that helps to reduce some of the cost barriers. According to my research, a person who is insured is more likely to seek healthcare than a person who is uninsured (Hoerster et al, 2011). To operationalize the variable of cost, I used health insurance status. Based on figure 3, as rurality increases, the insured population decreases. Based on figure 4, as rurality increases, the uninsured population also increases.

Rurality on Percent Insured

R² = 0.002

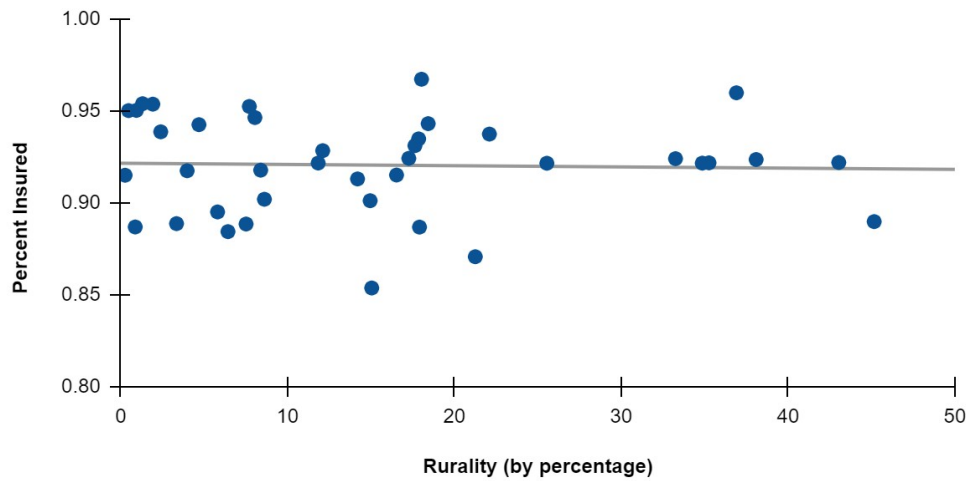


Figure 3: Relationship between rurality and insured population

Rurality on Percent Uninsured

R² = 0.002

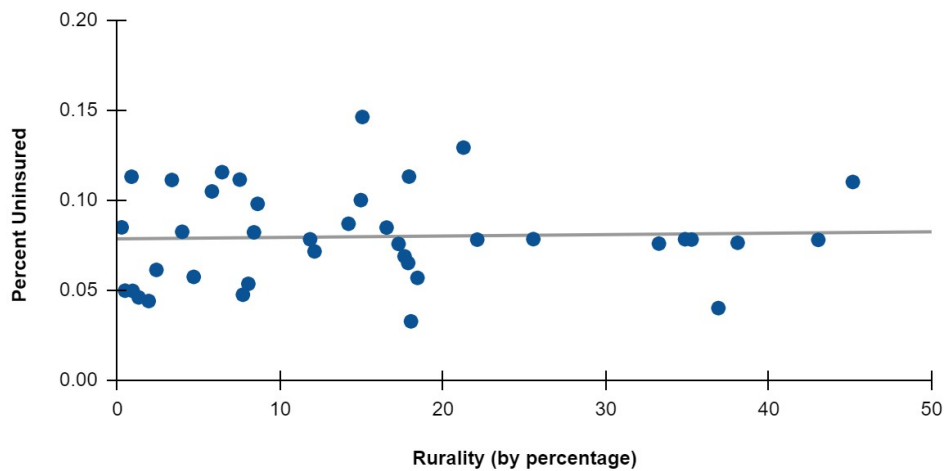


Figure 4: Relationship between rurality and uninsured population

Analysis of Findings

The scatterplots I generated did not support one of my hypotheses. I hypothesized that more rural counties will have fewer healthcare resources for residents than more urban counties.

While it appears that more rural counties have a lower number of hospitals, when I calculated

how many hospitals there were in each county per 100,000 people, the data suggested that there is a sufficient number of hospitals in each county. Figure 2 demonstrates that as the rurality percentage of population increases the number of hospitals per 100,000 residents also increases. The R value for this graph is 0.269, meaning that the relationship between rurality and the number of hospitals per county is not statistically significant, but there is a slight correlation. On average, there are 5.53 hospitals per California county per 100,000 people, the median is 3.56 hospitals, the minimum number of hospitals is 0, and the maximum number of hospitals is 42.09. Modoc county appeared as an outlier. This is because when the number of hospitals was adjusted to be per capita, the number of hospitals for the population in this county was 42.09. The raw data states that Modoc has 2 hospitals, but because it is 100% rural the number per capita increases significantly. These descriptive statistics support that the slight correlation indicates that there are sufficient hospitals per county in California thus disproving my hypothesis.

While my data analysis indicates that there is a sufficient number of hospitals in each county of California, the problem may be an issue related to distance. The problem may not be that there is an insufficient number of hospitals per county but that the hospitals are too far from a population of farmworkers in need of healthcare. As seen in my research, transportation is a barrier to farmworkers getting healthcare (Soto et al. 2022). Distance from a hospital is not something that I could measure using the data I analyzed. With this, the data can be skewed and/or affected by this unmeasurable factor. Furthermore, while my hypothesis was not exactly supported, there may be other factors that indicate that there are insufficient healthcare resources in rural counties in which farmworkers live and work.

My second hypothesis was that residents of more rural counties will seek healthcare less often than residents of more urban counties. To evaluate this hypothesis, I used the health

insurance status of populations of California counties. Based on my background research, I learned that a person who has health insurance is more likely to seek healthcare than a person who does not have health insurance (Hoerster et al, 2011). Figure 3 demonstrates a very slight negative correlation between the rurality percentage of a county and the percentage of the county population that is insured. The graph demonstrates that as rurality percentage increases, the insured population decreases. While it shows a correlation, it is not statistically significant as the R value is 0.002. The average county has an insured population of 92%, a median insured population of 92%, a minimum insured population of 85% and a maximum insured population of 97%. While these descriptive statistics indicate a high number of insured population, the figure shows a slight decrease in insured population as the counties become more rural.

To further analyze my hypothesis, I also analyzed the uninsured population in relation to rurality. Figure 4 demonstrates a slight positive correlation between rurality population by percent and uninsured population by percentage. The graph demonstrates that as rurality percentage increases the uninsured population percentage also increases. However, once more the R value is 0.002 meaning that it is not a statistically significant result. Regardless, the average county has an uninsured population of 8%, a median uninsured population of 8%, a minimum uninsured population of 3.3%, and a maximum uninsured population of 11.3%. While the descriptive statistics indicate a low number of uninsured population percentage per county, there is still a slight positive correlation between uninsured population and more rural counties.

The correlations in figures 3 and 4 complement each other meaning that there is a slight correlational relationship between insurance status of a population and rurality. Based on this correlation, more rural counties tend to have more uninsured populations. Farmworkers tend to live in more rural areas, in which it can be assumed they are more likely to be uninsured, thus

creating a cost barrier which would affect the rate of farmworkers seeking healthcare. This further establishes my hypothesis that farmworkers in more rural areas will seek healthcare less often than farmworkers in urban areas.

Implications

Knowing that farmwork is a dangerous occupation, I analyzed the capacity of healthcare available to farmworkers in rural areas. I made the assumption that many farmworkers work and live in rural areas to evaluate the barrier that they face as a result of the rurality. To evaluate the capacity of healthcare in rural counties, I analyzed the two main barriers of cost and distance that farm workers face when they seek healthcare (Cha and Barton 2022). To evaluate the distance barrier, I analyzed the relationship between rurality percentage and hospital number per 100,000 people. To evaluate the cost barrier, I analyzed the relationship between rurality and insurance status of the populations of the counties.

My results did not yield a statistically significant relationship between the rurality percentage of a county and the number of hospitals per 100,000 people. Based on figure 2 and the data that I collected, it appears that each county has a sufficient number of hospitals available to their residents and population. Perhaps using the measure of hospital number per county was not optimal to measure the distance barrier. Instead figuring out a way to evaluate how accessible the hospitals are to the surrounding populations would give more insight to the distance barrier. Additionally, part of the problem that contributes to the distance barrier for farmworkers is that many of them do not have a means of transportation (Soto et al. 2022). Perhaps if a survey in which data of the number of farmworkers who have a form of transportation is collected, it would lead to a better measure for the distance barrier.

My results also did not yield statistically significant results for the relationship between rurality and insurance status of a population. However, figures 3 and 4 complement each other to display that as rurality increases the uninsured population becomes larger. The insurance factor is an indicator of how the cost barrier affects a population. An individual is more likely to seek healthcare if they have health insurance than an individual who does not have health insurance (Hoerster et al, 2011). This is because health insurance can help to make healthcare more affordable. Farmworkers in need of healthcare who are uninsured might not seek healthcare as frequently as those who are insured. Additionally, many farmworkers live in impoverished conditions and classify as low income individuals, further instantiating the strain that healthcare would create if a farmworker does have health insurance (California Department of Housing and Community Development, 2023). Overall, farmworkers who work and live in more rural areas may not have insurance meaning that the barrier of cost is a problem and the capacity of healthcare in those areas is not sufficient.

Conclusion

With my research in mind, to address the issue of healthcare resources available in rural counties, a policy in which small scale clinics and mobile clinics are made accessible may help to alleviate the problem. These clinics could have a no questions asked policy in which immigration documentation is not asked, so to alleviate some of the fear factors that play into the accessibility problem for farmworker healthcare. Ensuring that these clinics are made accessible in rural areas where farmworkers do not have the means of transportation would ensure that their health is being taken care of without adding the stress of acquiring transportation. Policies to make healthcare more equitable would need to focus on ways of being more accessible.

Furthermore, to address the issue of individuals not having health insurance, a policy to make state programs even more accessible to those in rural areas could help to increase the frequency of healthcare use. Programs like Medi-cal are expanding coverage to more age groups, but it is a slow process. Additionally, as of recently people are losing their Medi-cal coverage as a result of not submitting proper documentation for renewals (Wolffe, 2023). The reason for this is because many of the recipients of Medi-cal find it challenging to understand how to fill out the paperwork as well as other contributing factors relating to post-pandemic effects. So, figuring out a way to make the application process and the program overall more accessible could help more people to gain health insurance. Currently, enrollment for Medi-cal is increasing, so the process in which the program is being expanded to more age groups appears to be helping more individuals gain health insurance. Another pathway for more people to get insurance coverage is to continue expanding programs like Medi-cal to undocumented farmworkers since the majority of farmworkers are undocumented (Office of Governor Newsom, 2022). These sorts of expansions would help increase accessibility to insurance, thus relieving some of the cost barrier to healthcare.

If I were to conduct this project differently with a bigger time frame, I would compare my results to those of urban populations. Throughout my project the comparison between rural and urban counties was drawn but I did not actually collect data on urban counties to compare. Drawing a comparison between urban and rural counties might have given different, more concrete results. Perhaps, this kind of data comparison would have given statistically significant results.

If I were to continue my research on the inequities in farmworker healthcare, I would want to run a study in which other kinds of healthcare resources and facilities are evaluated.

There might be a significant difference between the number of hospitals available to a county population versus healthcare facilities like urgent care or general practice physician offices. Measuring the capacity of healthcare available using only hospital capacity may not be the most comprehensive measure so including the capacities of other healthcare facilities would yield a more broad capacity measure.

Additionally, if I have an unlimited budget for research I would figure out a way to include the factor of documentation status. This is important specifically for the farmworker health care inequities because 90% of farmworkers are immigrants, a large portion being undocumented (Cha and Collins, 2022). Figuring out a way to alleviate some of the barriers like internalized fear of deportation could make healthcare for these groups more equitable. Understanding the factors that contribute to healthcare inequity, like those of internalized fears, could help us to learn how to gain the trust of these groups of people to better serve them. Farmworkers, especially immigrants, have a hard time trusting the healthcare system (The Dose, 2021). Having data on the insurance status of farmworkers who are facing healthcare barriers can aid in figuring out a way to make healthcare more accessible to them.

Overall, working in agriculture is a very dangerous occupation as explained by the background research. Farmworkers face numerous injuries, diseases, and illness but have a hard time getting medical attention as a result of healthcare inequities. Cost and distance are two of the most prominent barriers our farmworker population face. As seen in my data, the number of healthcare facilities in each California county may be sufficient, so the issue may be the distance a farmworker has to travel to get medical attention at a hospital. Furthermore, the more rural a county is, the number of uninsured people increases as well. This could affect the rates at which people seek medical care because it might not be affordable without insurance. Oftentimes our

farmworker population work and live in rural areas in which these barriers are more prominent. Developing solutions to make healthcare more accessible to these individuals is detrimental to ensuring our farmworkers are healthy to continue producing the large agricultural economy of California.

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