Health Care Access For Migrant Farmworkers: A Paradigm For Better Health

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Citation

P Clark, L Surry, K Contino. *Health Care Access For Migrant Farmworkers: A Paradigm For Better Health*. The Internet Journal of Health. 2008 Volume 8 Number 2.

Abstract

It is estimated that 9.3 million undocumented individuals are currently living in the United States. More than 15% of the United States' Gross Domestic Product (GDP) is spent in health care each year, more than any other developed nation worldwide; however, the benefits of the health care system are not uniformly felt by everyone living within our borders as more than 47 million Americans have no health care insurance coverage. For this reason, many utilize the emergency room for all of their health needs. Only 1 in 5 farm workers is able to obtain health insurance through either their employer or through the state or federal governments. The lack of health insurance makes it increasingly difficult for the uninsured and undocumented populations to obtain health care, as more than two-thirds of this population is living in poverty. To assist in delivering health care to these individuals and to help ensure necessary public health measures, the paradigm of a “Health Promoter” is being put forth to serve as a potential solution to cost-effective managed health care. The Health Promoter paradigm brings a third world concept to the first world. It is hoped that this paradigm can serve other hospitals and health care facilities to bring medical attention to other undocumented populations nationwide.

INTRODUCTION

Immigration and health care are two widely discussed controversial issues that are being debated politically, socially, economically, and ethically. Nationally, immigration has presented itself as an extremely complex issue, especially following the release of a recent estimate that 9.3 million undocumented individuals are currently living in the United States. More than 80% of these individuals have arrived from Mexico or other Latin American countries [1]. many of the undocumented immigrants, especially those from mexico, contribute to the nation's agriculture labor force, yet they are unable to fully utilize the health care system. they do not have access to emergency services via hospital emergency departments (eds) which, for non-emergent illnesses, is the worst possible venue. even though more than 15% of the national gross domestic product (gdp) is spent on health care each year, uninsured individuals are unable to reap the benefits of such services [2]. it is unlikely that a migrant farmworker, an individual who travels constantly following the peak seasons of agricultural crops in order to find work, is able to afford health insurance when the average salary for this occupation is $7,500 [3].

This issue has been viewed as greatly problematic for the state of New Jersey which has a high number of migrant farmworkers, estimated to be between 15,000 and 30,000 of which approximately 80% are undocumented [1]. the employee benefit research institute (ebri), reported in august of 2008 that “42% of new jersey's approximately 1.2 million uninsured residents are foreign-born” and “only california, texas, florida, and new york post higher numbers of uninsured residents who are immigrants [4].” although many legal farmworkers are eligible for health care through the government, those who are undocumented cost the state more than $200 million through use of emergency services, hospitalizations, and pre-natal, delivery, and infant and child health care [1]. in addition, $27 million was spent on outpatient care for undocumented individuals alone.

Cumberland County, the largest agricultural producer within New Jersey, reported that the 2000 County Census found approximately 3,068 migrant farmworkers are employed by agricultural farmers, nurserymen, and sod farmers; however, government officials now assume that this number is much larger than the census seems to indicate. With the lack of knowledge of preventative health measures and the inability to seek proper medical care, the farmworkers in Cumberland County, largely undocumented, are relying on emergency services, which are much more costly than preventative

medicine.

Health care is a basic human right, which is documented in Article 25 of the United Nations Declaration on Human Rights. Denying such services to any individual on the basis of their ethnic, legal, or financial status is morally wrong. Migrant farmworkers are a vulnerable population in that many of the workers are undocumented and few, if any, have health insurance, which severely limits their access to medical care. The farmworkers, who are an integral part of the production and prosperity of the United States agricultural economy, are often denied basic health care, which negates their personal dignity. Furthermore, providing health care to all is not an issue concerning only the patient that is ill; rather, it encompasses a public health dimension, which involves the health of all members of the community.

To assist in delivering health care to these individuals and to help ensure necessary public health measures, the paradigm of a “Health Promoter” is being put forth to serve as a potential solution to cost-effective managed health care. The Health Promoter paradigm brings a third world concept to the first world. It is hoped that this paradigm can serve other hospitals and health care facilities to bring medical attention to other undocumented populations nationwide.

The purpose of this article is three-fold: first, to provide an overview of the migrant farmworker population and an overall view of their health care needs from three distinct levels: national, state (New Jersey), and local (Cumberland County); second, to present a working “Health Promoter” paradigm to better the health care of the migrant farmworkers; and third, to give an ethical analysis justifying the necessity of the “Health Promoter” in the farmworker community.

NATIONAL LEVEL

In this election year, immigration of undocumented individuals into the United States has become a widely controversial topic. It is estimated that almost two-thirds of the approximately 9.3 million undocumented immigrants are concentrated in the following 6 states: California, Texas, Florida, New York, Illinois, and New Jersey. Overall, 5.3 million are from Mexico and 2.2 million are from other Latin American countries [1].

The productivity of the agriculture industry in the United States is dependent on labor provided by immigrants and seasonal migrant workers. Largely, these individuals lead nomadic lifestyles spending much of their lives traveling to find work. Migrant farmworkers travel from their native countries, primarily Mexico but also including Puerto Rico, Dominican Republic, Cuba, and many other Latin American countries, to agricultural locations within the United States. Each destination is chosen based on the demand for workers, which fluctuates with the season for each crop; however, not all of the 2.3 million Mexicans immigrants that comprise the United States agricultural work force carry out migrant behavior [5]. migrant behavior is characterized by seeking employment outside of one's home country, and traveling to find work in a location where one does not have a permanent residence. it is estimated that 1.4 million workers in this category display this type of movement throughout the country [6]. even though the situation involving migrant workers is almost identical throughout the country, there are some aspects of the problem, including legal issues of immigration, health care, medical problems, work conditions, and many others, that differ between the national and state levels.

Most farmworkers of Hispanic descent are able only to speak Spanish, which makes it increasingly difficult for them to assimilate into society. Only 1 in 10 workers claims to be able to read and write English [3], and 85% of farmworkers admitted to having trouble reading and writing regardless of what language was used [7].

The Pew Hispanic Center estimates that more than 500,000 unauthorized farm workers, which are defined as those without proper legal immigration status or those lacking proper documentation, are estimated to be employed throughout the United States; however, experts agree that the number greatly exceeds this estimate [8]. since 1993, the percentage of unauthorized workers has more than doubled from 25% to greater than 50% according to the united states department of agriculture (usda) [8]. as the us government has begun to take more extreme measures to keep undocumented individuals out of the country, an increasingly larger number of those entering the country without having the documents indicating legal immigration status have worked to keep their identities hidden.

The United States Department of Agriculture (USDA) estimates that as little as 11% of farm workers receive any type of insurance or benefits (health insurance, life insurance, transportation) [9]. The National Center for Farmworker Health estimates that only 13% utilize Medicaid [7]. when forced to live and support a family on just $7,500 per year, health care and insurance are far from the top of the

priority list. overall, 86% of farmworkers are uninsured and only 10% of migrant farmworker children are insured [3]. consequently, when an uninsured farmworker or a member of his or her family becomes ill and requires medical attention, the expensive costs cause them to avoid seeking medical care. this national problem is seen quite vividly in rural communities where farmworkers provide the majority of the manual labor required to keep up with the production of farms and nurseries.

Both men and women are hired to work on farms, but men are employed at a greater rate creating a ratio of 4 men to every 1 woman [8]. the average pay for a farmworker varies with the cost of living, so the compensation given for their hard work and heavy labor fluctuates from state to state. one unfortunate part of the situation faced by undocumented workers is the low compensation for the strenuous labor they provide. the workers are more than willing to work at a rate that is much lower than minimum wage, as life is much more difficult in their native countries. in addition, they are subject to discrimination and exploitation from the surrounding community, as many believe that the immigrants are invading their neighborhoods and taking jobs that could potentially be available to american citizens. with half of the farmworker population earning less than $7,500 per year, providing for their own basic needs as well as those of their families becomes increasingly difficult [3].

Agricultural employers are exempt from paying their employees' overtime, which makes financial difficulties even more troublesome for all farmworkers [6]. also, if farm owners employ fewer than 11 workers and do not run a labor camp (housing barracks provided to workers by the employer), they are exempt from many of the provisions set forth by the occupational safety and health administration (osha) [10]. this leads to further exploitation of the vulnerable migrant farmworker population.

It is estimated that more than 15% of the United States' Gross Domestic Product (GDP) is spent in health care each year, more than any other developed nation worldwide [2]; however, the benefits of the health care system are not uniformly felt by everyone living within our borders as more than 47 million americans have no health care insurance coverage [11]. for this reason, many utilize the emergency room for all of their health needs. only 1 in 5 farm workers is able to obtain health insurance through either their employer or through the state or federal governments. the lack of health insurance makes it increasingly difficult for the uninsured and undocumented populations to obtain health care, as more than two-thirds of this population is living in poverty [3].

Although the statistics provided are the best estimate and representation of information related to the migrant farm worker population, it is important to note that the accuracy may be severely skewed. Most of the numbers were generated through a census, which occurs just once every 10 years, and it is highly unlikely that the large number of undocumented individuals have been included in surveys and censuses, especially if they are not in the country legally. Therefore, the numbers are much larger and the problem more extensive on the national level.

STATE LEVEL- NEW JERSEY

New Jersey, also referred to as “The Garden State,” is comprised of 4.75 million acres of farms subdivided into more than 9,000 farms; 82% of farms are smaller than 100 acres. The average size of each farm is 81 acres [12]. there are approximately 400,000 undocumented immigrants living in new jersey [1]. it is estimated that there are about 15,000 migrant farm workers employed in new jersey during the growing season (march through august) and approximately 40% less during the off-season; however, an increasingly higher number of workers has begun to remain in the united states and make permanent residences. those who have decided to deviate from typical migrant behavior and establish a home in just one location have begun to bring their families into the country to live permanently and no longer travel to find work. this new trend began as a result of the increased security on the united states-mexico border, the high costs of travel, and the difficult living conditions in mexico. other sources claim that there are as many as 20,000-30,000 migrant seasonal farm workers of which up to 80% are undocumented [13]. most migrant workers living in new jersey during the growing season travel either back to their home country or to florida or other southern states to find winter work. the number of workers employed by a particular farm varies greatly throughout the year with the largest staff needed in the spring and summer months.

At a typical farm in Southern New Jersey, the owner employs approximately 20 workers year-round with a large increase in staff size during the peak months resulting in a labor force of almost 50 individuals. During the picking seasons, farmers depend on the work of more individuals, since fruits and vegetables may rot if they are not picked at the appropriate times. Major crops include peppers, lettuce,

cabbage, tomatoes, onions, peaches, and apples. Migrant labor is also used on sod farms and nurseries. In general, most seasonal workers return to the farm or nursery at the beginning of the peak season each year; however, for those who do not return there are far more individuals seeking their jobs than there are positions for them. No specific numbers exist to illustrate this point, but during interviews in June of 2007 with three South Jersey farmers who have requested to remain anonymous, they stated that they have to turn per diem workers away each day; a greater number of laborers come to request employment for the day than assistance is needed.

Access to health care is difficult, as insurance is not provided for the majority of farmworkers, regardless of their immigration status. Approximately $200 million dollars are spent on health care for undocumented immigrants in the state of New Jersey each year, which is funded by state tax payers; however, much of this amount is spent to treat diseases and illnesses that have reached an end-stage or have progressed to a level that requires specialized attention [1]. primarily, most of the money spent on health care for undocumented immigrants is concentrated in the following areas: emergency medical services, well-baby maternity care, delivery, and after-birth care for infants and children. emergency medical facilities are generally utilized, because rarely do hospitals ask for immigration status. in 2004, an estimated $27 million was spent on in-patient care for those unable to provide a social security number.

Cumberland County is the largest agricultural producer in the State of New Jersey, leading all other counties in sales by more than $39 million per year. Specifically, it is the largest producer of vegetables, melons, potatoes, nursery stock, and sod in the state [14]. according to the cumberland county health department, the county employs an average of 3,068 workers, which includes both in-season and off-season labor forces; however, it is estimated that this figure is lower than the actual number of workers. the 2000 census also reported that 16.03% of the county population considered themselves to speak english “less than very well” making communication between members of the same community difficult. further, it showed that 19% of the population is hispanic comprised of 13% puerto ricans, 4% mexicans, and 2% regard themselves as “other.” overall, the major problem is that the numbers provided by the census do not accurately indicate the true number of hispanic people or the proper break-down of their specific backgrounds. this is because such a large proportion of the population is mexican and most of them are undocumented and cannot be tracked by the census [15].

In Bridgeton, New Jersey, one of the largest towns in Cumberland County where many legal as well as undocumented immigrants reside, 61% of the population of 22,777 is considered to be non-white. Approximately 66% of the citizens consider themselves to have Hispanic or Black ancestry. About 27% of the population lives in poverty, and the median income is $30,502 [16]. in accordance with the 2000 census, 24.5% of the population is hispanic, but the local government now assumes that this number is too low and therefore, not accurate [16].

When interviewed in June of 2007, a local farmer (who has requested to remain anonymous) stated that without the labor provided by these individuals, many farms, including his own, would cease to operate. It would be impossible to make deliveries, plant and harvest crops, and even load trailers. Many farmers have even gone as far as to say that their farms could be lost permanently if inexpensive labor was not available. Farmers cannot afford to pay laborers high wages, because the farming economy is not highly profitable. If more money had to be dispersed for payroll expenses, it is likely that the owners of the farms, especially small ones, would become bankrupt. Since more than 50% of the agricultural work force is undocumented and are paid “under the table,” it is assumed that the reported number of workers represents just half of the actual number of workers [5].

As with any group of individuals, good health is imperative for workers to perform at an effective level. With very low wages and no health insurance, farmworkers and their families are unable to take the proper measures to prevent disease and have even more difficulty in treating illnesses when they have progressed. For this reason, it becomes necessary to consider the means by which these laborers can achieve a healthy lifestyle for themselves and their families, which is an issue of justice and human rights.

In 1962, the Migrant Health Program (MHP) was founded to serve the farm worker community that lacked access to such services. The aim of this initiative was to provide grants that would help in lowering the cost of medical care for agricultural migrant workers. To prevent further stigma toward the largely Mexican migrant farm worker population, the MHP was run out of private practices. To parallel this program, Community Health Care Centers (CHC) were started throughout the country to serve not only migrant farm workers but underserved areas in general [17].the health

centers are funded through the federal and state governments as well as through grants [18].

In Cumberland County, CHC has two primary sites as well as 3 school-based locations, provides primary dental and medical care support services (counseling, health education, translation service, and transportation)[18]. the new jersey department of health and senior services funds vaccinations for 600 children each year; additionally, it finances a program to encourage primary care and reduce the number of patients traveling to the emergency room for conditions that are not urgent [18]. chc sees patients and charges fees according to their ability to pay. the scale creates a dual payer system; the patient pays a portion of the fee and the federal government covers the remaining amount that the patient is not able to provide; however, immigration status is likely to be questioned [12].

The economic aspect of this health care dilemma makes locating funds for the health care needs of farm workers difficult. One assistance program, Charity Care, is based upon family size, income, and proof of New Jersey Residency; immigration status is not an issue. New Jersey Hospital Subsidy Charity Care is provided to hospitals for services rendered within the hospital setting. It covers the costs of performing services and tests as well as room and board, but it does not provide reimbursement to the physicians for professional services provided. Funds for the program are part of the state budget and are subject to legislative cuts through the budget process [19]. this program makes it possible for undocumented individuals to obtain assistance without disclosing their immigration status. the patient must provide documentation, which presents an additional level of difficulty for those who are paid “under the table” or those who have just begun working in new jersey. employers are supposed to pay their workers by check; however, many farm workers are paid “under the table,” because if no documentation is present, farmers cannot be held accountable for hiring undocumented workers and are not bound by the rules of osha [17]. for the farmer, this is the benefit of hiring undocumented workers.

It has been suggested that 15-20% of all workers nationwide are paid in this manner, which prevents social security, workers' compensation, and income taxes from being paid by both the employer and the employee [20]. charity care applicants are only eligible for the assistance program if they are able to show a record of income for at least three months. for a family of four, if the gross household income is less than $38,700, the family is eligible for the service. this program reimburses hospitals for treatment to individuals who are living in new jersey if their income is below the indicated amount [21]. as a result, there is no documentation or record of employment status. a physician in cumberland county new jersey, dr. lori talbot, md, has created a document that can be completed by a farm worker's employer that states the duration of past employment, the length of future work, and the approximate income of the worker. for those seeking care in cumberland county, this can be used in place of a pay stub to prove the employment status of a worker. chc falls under the category of federally qualified health centers (fqhc) which are created under medicare and medicaid; consequently, the centers are able to receive reimbursement from these organizations [17]. these clinics provide primary care and limited specialty care. physicians employed by fqhcs do receive payment for the services that they provide [22].

One major problem associated with Charity Care is that it only covers tests and blood work which are performed in the hospital setting, and does not pay for any additional treatments that a patient may require following the results of the test. For example, if a Charity Care recipient has a number of tests performed at the hospital and learns that he or she has cancer or another illness or condition requiring additional care, the costs associated with the treatments will have to be covered out-of-pocket. [22].

Some physicians have claimed that when they have a patient with a life-threatening condition and the inability to pay for tertiary care, it is often much easier to contact a colleague specializing in this area to perform the procedure at a reduced cost if the primary care physician (PCP) has been practicing in the area for an extended period. This proves to be a difficult plan for a physician who is new to a particular area and has not yet established working relationships with other medical professionals. Regardless, there is a limit to the number of patients that a specialist can treat without cost. Fortunately, some non-profit groups, such as the Migrant Clinicians Network, have compiled a list of organizations that provide financial assistance to farm workers with excessive medical bills [21].

Although it is true that it requires money to obtain health care, there are a number of programs that are available to farm workers, regardless of their immigration status. For this reason, it is necessary to implement the health promoter program to educate and help monitor the health of this

vulnerable population.

OVERALL HEALTH CARE ANALYSIS

The American Farm Bureau estimates that without the help of illegal aliens, the agricultural sector of the economy would lose between $5 and $9 billion in flowers, fruits, and vegetables and would cause more than 20% of the production to move overseas [23]. the help provided by migrant farm workers is critical for the agriculture sector of the united states economy; however, the constant exposure to dangerous living conditions, hazardous chemicals, and long hours in the heat have proven to impose serious medical problems for many of those workers.

An added obstacle in providing the most beneficial care to migrant workers is the Hispanic culture that encourages the use of lay healers, which may provide patients with teas, herbal remedies, and even creams that are thought to heal many types of ailments. It is commonplace for patients to see a healer rather than a physician for two reasons. First, many workers are unable to afford the cost of a doctor visit. The second reason for seeking help from healers rather than from physicians is the fear of being reported to INS and consequently being deported. Now, there are two known lay healers (who practice traditional medicine) living and working in Bridgeton along with one store that makes traditional herbal remedies native to the Hispanic culture available to the public. Because of low wages, most farm workers cannot afford insurance and are therefore, required to pay for office visits, treatments, and prescriptions from their own resources. Those who are in the country illegally avoid going to any location or institution where they are made to present identification or where a record of the visit can be documented, which prevents many individuals from seeking proper medical care [23]. consequently, little preventative care is provided to their patients.

It is important to note that a physician who upholds the patient-physician relationship and upholds confidentiality, will not consider immigration status as a deterrent to treating a patient (i.e., will not report to INS). Often at this point, medical conditions have exceeded a level that can be treated at a clinic and the patient must be hospitalized or referred to a specialist where the cost of treatment is usually higher than it would have been if treated at an earlier stage [21]. the disease or condition may have been prevented had these individuals utilized preventative measures.

Most of the Community Health Clinics are federally funded, but patients are still required to pay a fee, which can be adjusted on a sliding scale. For farmworkers who work long hours, the major problem is that the clinics do not have hours in the evenings. Farmworkers are often only able to see a physician in the evenings. In addition, most farmworkers will go to work even when they are ill, because they are paid hourly and are not given sick days. [24]. overall, the major issues farmworkers face in seeking health care are transportation to the clinics, finances, fear of deportation, and communication needed to form the patient-physician relationship.

MEDICAL CONDITIONS

In the migrant farmworker community, there are four common types of health problems: 1) chronic non-infectious diseases; 2) allergic condition conditions; 3) work-related physical injuries; 4) infectious diseases such as Tuberculosis, HIV/AIDS, and Sexually Transmitted Infections (STIs).

The first category of medical conditions is comprised of chronic non-infectious diseases most frequently seen among migrant farmworkers, which are similar throughout the United States. This is because the nature of their work is nearly the same in California or in the Midwest as it is in Bridgeton, New Jersey. Common chronic diseases are diabetes and hypertension. Diabetes is largely attributed to a genetic predisposition and is twice as common in the Hispanic population as it is in those with Caucasian backgrounds [21]. because most farmworkers have a low budget for food, they consume foods that are inexpensive and eat very few of the nutritious foods, such as proteins, fruits, and vegetables that are traditionally more expensive. meals generally consist of tortillas, rice, beans, and sugared drinks, none of which help to reduce the symptoms and detrimental effects of diabetes. these high carbohydrate diets greatly intensify the genetic factors of diabetes [21]. the high incidence of obesity also contributes to the large number of cases of diabetes. this is the result of unbalanced meals and frequent consumption of fast food. hypertension is another chronic disease resulting from both lifestyle and genetic factors. with regular check-ups, medication, and lifestyle changes, hypertension can be controlled; however, this common disease in the hispanic migrant population is often ignored, as many individuals cannot see a physician regularly, which often results in more serious medical conditions [25].

The second category of medical conditions includes allergic conditions. Many of these conditions are attributed to individuals working in dry, dusty fields. Farm workers have

an increased risk for hay fever and similar allergic conditions as they are constantly exposed to numerous environmental irritants [26]. moreover, asthma is aggravated by work done outside and under dusty, dry conditions [25]. some individuals have reactions to pesticides and chemicals used on crops, while others develop skin conditions from plants, various substances, allergies, or even pests. while many of these are not difficult to care for at early stages, allowing them to go untreated can result in more dangerous conditions such as infections [21].

The third category of medical conditions that require medical attention is that which includes work-related physical injuries. Many farmworkers suffer sprains and strains, pain in their joints and backs, and various other orthopedic ailments. These injuries are the result of repetitive motions common to farm labor, such as bending over to pick crops, cutting stalks of vegetables, and lifting boxes on a regular basis.

The fourth category encompasses a number of infectious diseases such as Tuberculosis (TB), HIV/AIDS, and Sexually Transmitted Infections (STIs) also exist [27]. the community style living allows for a quick spread of infectious diseases including parasites and airborne and communicable fungi, bacteria, and viruses. because of the close quarters, if one person contracts a condition, others have a higher chance of infection [28]. between 37% and 48% of farmworkers tested in a recent study tested positive for tuberculosis [27]. the prevalence rate for the population at large is 5.7% [29]. this is a public health matter that is of importance to the community because of the communicable nature of the disease. for example, school-aged children are especially susceptible to such illnesses as they are constantly coming into contact with classmates. if students with tuberculosis are permitted to attend classes, they put the remainder of the class at risk. furthermore, such exposure could occur at any public location if an infected individual continued to go untreated. a common plight among immigrant communities is the fear of disease. those who are undocumented may hesitate to seek treatment, which allows the condition to escalate as well as spread to others.

The HIV/AIDS prevalence rate for this population has been determined to be between 2.6% and 10%, which is significantly higher than the national level of 0.6 % [30]. when those entering the community are infected with hiv/aids and begin to have intimate relationships with uninfected members of the community, there is an increased chance for one to contract the disease. with a high incidence of sexually transmitted infections (stis), the spread of hiv is a valid concern. the reason for the high sti rate is twofold. first, many farm workers are very young with an average age of 34 years [7]. of these individuals, some are married; however, since a large portion is in the country illegally, it is increasingly difficult for them to travel back and forth between the united states and mexico because of fear of being unable to return to their families. condoms are not widely accepted in the latino community, because the individual may be catholic and the use of artificial contraception is considered a moral evil. in addition, it is thought that condoms are only used for relations outside of marriage [31]. considering these two points, it is evident that the level of stis in this community of individuals would be increased. the farmworker population also suffers from alcoholism and depression. alcohol is often used as a self-prescribed way to treat the difficulty of being away from one's family. depression is largely attributed to migrant workers being away from their families, as they often travel without their wives and children [21].

Not only do the medical conditions that farmworkers face present problems, it is the ways that they are treated that make the situation more complex. Acquiring the proper medications provides a high level of difficulty because of the price of prescriptions and the location of the pharmacies. Often, when patients do see a physician and are written a prescription, they never have it filled because they lack the financial ability to do so or the pharmacies are located in inaccessible areas. Many times individuals have been taking medications that they have brought from Mexico or have had family members mail to them, since the cost is so much less in their home countries [21]. this presents a dangerous problem for the health care provider, since the patient may be reluctant to tell the physician of a drug that he or she is taking. sometimes the patient is not sure of the actual drug that he or she has self-prescribed, which makes it difficult for a physician to prescribe a drug that may counteract other medications. this may also lead to adverse medical conditions that could potentially be deadly. the same dilemma arises when a patient has been taking herbal remedies and supplements from lay healers, who are generally people in whom the patient has invested a great deal of confidence. fortunately, for physicians attempting to treat patients on strict budgets, wal-mart has created a program that offers 360 prescription drugs (of which most are generic) and more than 1,000 over the counter drugs for just $4. the prescriptions provided represent more than 95%

of the most commonly prescribed drugs and can be provided in 30-day and 90-day supplies [32]. unfortunately, though, a few problems still exist. first, like many other services that are available, many farmworkers do not know of the program. secondly, while there is a wal-mart in bridgeton, transportation for some of the workers in the rural communities (some of which are as much as twenty-five minutes away) presents further difficulties.

The lack of consistent medical records provides an additional challenge. Generally, migrant farm workers travel without any type of written evidence of their past medical history. It has been suggested that once a test is performed on an individual who does not have a permanent residence, he or she should be given a copy of the results immediately so that the next time the patient sees a physician for any reason, the health care provider will be aware of the results. When treating migrant workers, doctors should provide the patient with a card, which displays the physician's contact information in case another physician providing care to this individual in the future needs to discuss the patient's records and history. Providing a patient with this information is the standard in many third world countries. One idea proposed to avoid the dilemma of medical records is the creation of portable medical records. Due to the level of difficulty in transferring all of a patient's information into electronic status and the high costs, this system could take up to 20 years to perfect; however, many initiatives are beginning to take place. Some other concerns and obstacles include cost, and historical competitive environment between and among care providers, which goes along with a past lack of trust. A fear is that providers will “steal” patients from one another, as if anyone actually “owns” a patient [19]. the plan is to move all records (ekg, ct scans, mri, blood test results) into a universal database [33]. this initiative has begun in bridgeton, so that all records can be accessible to participating physicians both domestically and internationally. this project would promote consistency, especially among pregnant women whose prenatal records are imperative in the proper treatment of the mother and child. the problem, however, lies in a possible lack of confidentiality provided by such a system. in order for this method to be established, appropriate measures would have to be taken to ensure that personal information is protected. with the hippa laws in place, this fear is somewhat mitigated if the creator of the community health record/health information exchange is acting in accordance with the laws. there are several layers of security in the creation of a system like this. for example, in the health information exchange currently being designed at atlanticare in southern new jersey, several levels of security are being implemented to protest both the patients and the providers. in the shared database for patients, there will be a number of clinical diagnoses and records information that will be behind “break glass,” meaning that a practitioner wanting to access that information would have to provide documentation in the record of his/her clinical need to obtain such information for the treatment and care of the patient [19]. the fear is that if confidential information is not properly protected, high levels of discrimination will occur toward that person [34].

In order to provide for the medical needs of this vulnerable population and reduce the costs faced by the state each year, a health promoter paradigm will be presented for use in the migrant farmworker population and as a model for underserved populations nationwide.

HEALTH PROMOTER MODEL

The health promoter model incorporates the successful and applicable aspects from Third World models and then adapts them to the resource-poor conditions in the developed world, and particularly in Cumberland County, New Jersey. The hope is that this “health promoter” program could serve as a paradigm for other United States hospitals to adapt to the challenges of reducing health care costs, particularly, in light of immigration. The main focus of the health promoter model is designed for the prevention of complex diseases and management of chronic conditions through education and observation. The “Health Promoter” model was created with the following goals and objectives:

- Create a community-based program involving a high degree of community participation.
- Provide quality health care services by partnerships with other already established organizations in the area.
- Reduce the costs of health care for uninsured or underinsured individuals and demonstrate cost-effectiveness for all members of the partnership (hospitals, health care providers, sponsors of the program, and the members of the community).
- Improve the health of the poor and marginalized individuals of the immigrant and impoverished communities of New Jersey using education and increased access to primary health care services in the prevention and/or management of illness.

When implemented over the course of the next year, the Health Promoter model will be a cooperative effort, including community members, Community Health Care and health care professionals in Cumberland County, New Jersey. With respected community members serving as health promoters, the hope is that the community will view this program as being grounded in transparency and trust. Ideally, it will also generate a sense of community ownership, by encouraging the active participation of community leaders to address the wants and needs of their communities through services provided by the Health Promoters.

The primary role of the Health Promoter will be providing health and nutrition education in the individual homes, monitoring patient health and compliance with a prescribed medical course of treatment, and referring patients to a clinic or hospital when needed. To meet the needs of the migrant farm worker communities, Community Health Care and associated clinics will offer various medical services. At the clinics the physicians will review any documentation by the Health Promoters; evaluate the patient; and prescribe diet, patient education, medications, or any other medical course of action. The Health Promoters will then be responsible for patient follow-up to ensure compliance. Social services will also be available to initiate enrollment in Medical Assistance programs to provide a more long-term and sustainable solution. The promoter will also be trained as to how to engage lay healers and discuss their goals, jobs, and place in the care of patients.

Secondarily, the Health Promoters will be asked to provide cultural and religious sensitivity training and education to hospital professional and clerical staff. This approach of reciprocity makes the Health Promoter program even more unique. It is believed that this practice will also increase the stature of the health promoters as well as increasing respectful interactions with the community in general. Ultimately, the hope is that such sensitivity will encourage community trust, participation and cooperation.

Having established the role of the Health Promoter, it is then necessary to establish the qualifications and criteria to be used in selecting Health Promoters. The health promoters will work exclusively within their own individual immigrant communities. This is an important aspect because there are numerous migrant farm worker groups represented in the southern New Jersey area. This cultural, linguistic and economic diversity has led to some tensions between the various groups represented within the community.

Therefore, it is necessary that individuals and community leaders within these specific groups spearhead the selection process. To ensure the Health Promoter will create a cooperative and trusting environment between the community and Community Health Care a number of criteria to serve the community as guidelines in their selection of a candidate have been created. The qualifications recommended for Health Promoter candidates, which has been derived from those used in the Dominican Republic at the Institute for Latin American Concern include:

- Well-respected in the community
- Trustful and trusted
- Committed to stay in the community during their time as Health Promoter
- An individual with extensive knowledge of the members, history, and life in the community
- Respectful of the ideas and traditions of the community
- An individual who possesses a spirit of service
- Devoted to the community (not seeking individual economic interests)
- Able to read, write, and communicate effectively
- A responsible, unbiased individual
- Aware of their own limits and capabilities
- Dynamic
- Capable of honoring patient confidentiality
- Team-oriented
- Permanent resident who is a farmworker
- Intent to remain a member of the designated local farmworker community

The training of the health promoters will be contingent upon the concerns of the community and what they communicate as their wants and needs. To determine the wants and needs of the migrant farm worker community in southern New Jersey, members of Community Health Care met with local hospitals, clinics, physicians in Cumberland County, as well as various community religious leaders. Based on the information obtained at these meetings and information

obtained from the Community Health Care staff, it was determined that the Health Promoters will need extensive education and training in the areas of nutrition, exercise, sanitation, and compliance with medications to address the five primary medical concerns: hypertension, diabetes, obesity, tuberculosis and HIV/AIDS. They should also be trained in clinical techniques such as documenting patient history, symptoms, and notes on the patient's condition; taking blood pressure, blood sugar levels, and heart rate; and performing Directly Observed Therapy (DOTs) for patients, who are unable to comply with medication (i.e. insulin and TB antibiotics). In addition, non-clinical, practical training is also important and should include such issues as protection of patient confidentiality, cultural sensitivity, communication skills, etc.

Training and education should include lectures, clinical demonstrations, and practical components for the Health Promoter candidates in preparation for their various responsibilities. The materials for such education and training should be readily available in most hospitals or should be easily attainable at a relatively low-cost, but may vary depending on community needs. The recommended basic training materials would include:

- A training manual which would be composed by the medical team in the hospital responsible for the training. It would include information covered in lectures (i.e. nutrition/diet, confidentiality, a glossary of applicable medical terminology, instruction on proper documentation and basic procedures, as well as basic medical background on hypertension, diabetes, tuberculosis, etc.) as well as any other useful information as determined by the medical staff educating team. Once again, this will be dependent on the needs of the community.
- Sphygmomanometers and stethoscopes for demonstration purposes as well as for post-training practical duties of the health promoters.
- Dry-erase boards or chalk boards, and projectors as needed for instructional purposes.

To determine the curriculum, establish requirements for completion of the training, and to organize and supervise the training, an education and training committee will be formed. This committee will also be responsible for determining the locations, times, and instructors for said training, as well as for assessment and evaluation of the Health Promoter candidates. Community Health Care, local churches and libraries have classroom or conference room spaces that would be ideal for the training of the health promoters. Qualified instructors for the education and training components can be health care professionals from within the Community Health Care system. This will help to greatly reduce costs.

The education materials, instruction, and training will be provided at no charge to Health Promoter candidates however, there will be a tremendous amount of work and dedication expected from the trained Health Promoters. Considering the significant commitment to training and service, the individual Health Promoters and the communities they support should be offered some incentives for participation. The following are some recommendations for incentives:

- Paid employment depending on duties, responsibilities, and designated qualifications.
- Scholarships awarded to selected health promoters of the community for continuing education
- College level classes provided to the health promoters through partnerships with Cumberland County College and/or assistance in obtaining a General Education Development (GED) degree
- Community projects through partnerships with city development programs (i.e. community center to hold after-school programs, a youth leadership program, or adult education classes; parks; etc.)

These incentives can be funded through government grants and philanthropic foundation grants. The hope would be that the promoter would be funded though the local Community Health Care system or by way of a state subsidy. For example, Mercy Hospital of Philadelphia will initiate this health promoter model, which will be funded through their free clinic and will be staffed by medical residents, which ensures sustainability.

It is hoped that such incentives will attract candidates willing to dedicate themselves to serving their communities. The Health Promoters will be capable of delivering the primary care desperately needed within the untrusting and fearful immigrant communities. For the positive impact of this cost-effective mechanism of primary health care delivery to be

observed, communication and confidential record keeping is critical. Secondarily, it would be ideal to do so with little or no infrastructure, storage space, or computers.

In order to meet these record keeping criteria, a solution was adopted from the contemporary practice in Africa. As is the case in many African countries, patients will maintain possession of their own charts. This solution meets the goals of confidential documentation with little infrastructure in using a practice familiar to many of the foreign immigrants. The possession of one's own medical records will also assist members of this population in maintaining continuity of care despite frequent relocations of such individuals due to employment or personal concerns. This solution will relieve one issue of patient trust in the program by removing the possibility of the inclusion of material in the patient's chart without the patient's knowledge. It places more responsibility upon the patient, which will hopefully have the effect of increasing a sense of ownership of the Health Promoters program throughout the community.

If a patient should be referred to a clinic or hospital, they would bring their chart with them. With consent, the patient's medical chart will be copied and included among the regular institutional records. This record will serve as a contingency in the event that a patient loses his/her chart, forgets to bring such documentation with him/her to the hospital or clinic, or arrives at a hospital or clinic in acute or emergency circumstances in which the patient is unable to bring this documentation.

In addition to individual patient documentation and record keeping, records of the number of patients seen, the most prevalent medical needs and costs will be recorded. This will be done by assigning an anonymous personal identification number to each participant in the Health Promoter's program. The number will also be included in the patient's medical record and a log will be compiled. This log will consist of ID numbers and the corresponding conditions of patients that will be collected through weekly reports submitted by the Health Promoters as well as through data collected at the clinics or hospital. These data will be compiled with the additional purpose of a financial assessment of the cost-effectiveness of the Health Promoter Program.

Financial assessment will include a comparison of the program costs with previously compiled data on the costs of treating undocumented individuals to date at Community Health Care. Such record-keeping techniques can also be utilized for quality assessment of the Health Promoter Program and individual health promoters via community surveys, health promoter comments and physician feedback. To measure clinical effectiveness, a model would have to be designed and implemented.

In our society, which is quite litigious, questions arose about liability coverage for the Health Promoters. After consultation with legal counsel, it was determined that legal liability for the Health Promoters would be of minimal concern. However, to protect all parties concerned, individuals seen by the Health Promoters could be asked to sign an acknowledgement in which the person receiving services acknowledges that the Health Promoter is not a physician or licensed health care professional. Consideration could also be given to asking the person receiving services to waive any potential legal claims against the Health Promoters.

The fact is that this program will cost money and will utilize significant resources in the short-term; however, it is believed that the Health Promoters program will prove tremendously beneficial and cost-effective in the long-term. To help defray the costs for Community Health care, funding will be sought for financial support of the program through federal, state and local grants as well as through private grants. The grant proposals and contributions will come from local universities who wish to be involved with this program.

In the last four decades, this nation has been trying to improve the quality of our health care delivery system. Despite the efforts to increase the quality in health care, disparities continue to be prevalent and have led to unjust consequences for racial and ethnic minorities. Advances in technology and a better understanding of the disease process have greatly improved due to research in the field of medicine. This has contributed to better management of the disease process, which has in turn improved the morbidity and mortality rates of many patients and increased life expectancy in this country. Unfortunately, this effect is being seen predominantly among white Americans while other ethnic groups are still vulnerable, especially inner city African American and migrant farm workers [$_{35}$]. even though, our health care system, in principle, is considered to be the best in the world it has its own flaws and has left millions of americans as well as documented and undocumented individuals with inadequate health care or no access to basic health care services.

Migrant farm workers in general are predominantly Latinos, but the majority of the workers come from Mexico. This population has special needs which physicians and hospitals are not well-equipped to provide. The majority of this community is suffering from chronic diseases such as hypertension, diabetes, obesity, TB and HIV/AIDS. As health care providers, our duty is to improve the health of the community we serve. To achieve this goal it is important to understand the diseases prevalent in this community and to develop services tailored to meet these needs. This is certainly a medical problem, but it is also an ethical problem for all Americans. To allow race and ethnicity to play any role in providing health care to our fellow brothers and sisters goes against the basic principles of ethics. It will be argued that—according to the ethical principles of respect for persons, beneficence/nonmaleficence, and justice—action must be taken immediately to address these concerns. Such action will not only save lives, but will also do much to rebuild a sense of trust between the minority community and the medical establishment.

RESPECT FOR PERSONS

This principle incorporates two ethical convictions: first, that persons should be treated as autonomous agents; and second, that persons with diminished autonomy are entitled to protection. The principle of respect for persons thus divides into two separate moral requirements: the requirement to acknowledge autonomy and the requirement to protect those with diminished autonomy [36]. respect for human persons refers to the right of a person to exercise self-determination and to be treated with dignity and respect. all people deserve autonomy and to be treated with dignity and respect. failure to provide any person with adequate health care, regardless of their race, creed, color, national origin, sexual orientation, etc., violates this basic right of respect for persons. fear that undocumented individuals will be turned over to the ins if they seek medical care violates personal freedom. it subjects all undocumented persons to the most terrible form of slavery, to be constantly afraid, not knowing their condition or fate, and constantly fearing not living. this way of living does not promote human rights, it violates them.

Second, minorities in this country and especially the undocumented are the most vulnerable people. When immigrants, especially undocumented immigrants, arrive at a particular farm, they are often exhausted and fearful. They are seeking employment and have little financial support on which to fall back. In addition, some may be in poor health, often because they have moved from town to town, farm to farm and have been exposed not only to the elements but also to herbicides and pesticides. The average income is $7,500 per year and most have no health care insurance or benefits. Communication is also an issue with the majority being uneducated and unable to read or speak English. This vulnerability compounded with racial disparities give these individuals diminished autonomy. In 2002, an Institute of Medicine (IOM) report, which was requested by Congress, reviewed more than 100 studies that documented a wide range of disparities in the United States health care system. This study found that racial and ethnic minorities in the United States receive lower health care than whites, even when their insurance and income levels are the same [37]. the iom report made it clear that disparities between whites and minorities exist in a number of disease areas [38]. these disparities are even greater among the undocumented population. giselle corbie-smith, md, and her colleagues found that african americans were “more likely to believe that their physicians would not explain research fully or would treat them as part of an experiment without their consent [38].” medical abuses have come to light through the oral tradition of minority groups and published reports. african americans believe that their physicians cannot be trusted, that physicians sometimes use them as guinea pigs in experiments, and that they are sometimes not offered the same medical procedures that whites are offered, even though they have the same clinical symptoms [39]. this fear and mistrust among the african american population in the united states is also present among the hispanic peoples and is magnified with undocumented individuals. the result is that many undocumented and even documented hispanic migrant farmworkers in the southern new jersey area are not seeking medical care until they are in the last stages of their disease. the reason for this, according to those who work with this population and have gained their trust, is a mistrust of the medical establishment and a fear that if they present to an emergency department and are found to be undocumented that they will be turned over to the immigration and naturalization service (ins) for deportation. unfortunately, this has happened in a number of cases. even though most hospitals will not contact ins in these situations, there is still a great fear among this population. because of this fear, these individuals enter the medical system only out of desperation, when they can no longer stand the pain or have collapsed in a public setting. in most cases, the disease has progressed to the extent that treatment is often futile or extremely expensive. this sense of fear among the undocumented population violates the basic principles of respect for

persons. failure of the medical establishment to give this population adequate health care or to withhold treatment that is the "standard of care" because the individual is undocumented or unable to afford said treatment is denying these individuals their basic rights of dignity and respect. the medical profession is based on treating all people with dignity and respect. until we can show an improvement in the overall quality of care and work to aggressively promote public health interventions on such diseases as hypertension, diabetes, obesity, tb, hiv/aids, etc. for minorities in general and the undocumented specifically, we will never gain the trust of the minority communities and will never close the ever-widening gap in quality of care.

The failure of the medical profession to be proactive in addressing the medical needs of this most vulnerable population is causing needless suffering and even death. This form of prejudice clearly violates the ethical principle of respect for persons. Minority patients' autonomy and the basic respect they deserve as human beings, is being violated because they are allowed to endure pain, suffering, and even death when such hardships could be alleviated. All hospitals, and especially Catholic hospitals, governed by the Ethical and Religious Directives for Catholic Health Care Services, have a moral and ethical obligation to address the medical disparities that exist in the minority communities [40]. if catholic hospitals are committed to treating every person with dignity and respect, then the barriers to health care must be lifted to ensure this commitment, and emphasis must be placed on patient dignity and empowerment.

BENEFICENCE/NONMALEFICENCE

The principle of beneficence involves the obligation to prevent, remove, or minimize harm and risk to others and to promote and enhance their good. Beneficence includes nonmaleficence, which prohibits the infliction of harm, injury, or death upon others. In medical ethics, this principle has been closely associated with the maxim primum non nocere ("Above all, do no harm"). Allowing a person to endure pain and suffering that could be managed and relieved violates the principle of beneficence, because one is not preventing harm and, therefore, not acting in the best interest of the patient. The duty to act in the patient's best interest must take preference over a physician's self-interest.

Physicians have, as moral agents, an ethical responsibility to treat their patients in a way that will maximize benefits and minimize harms. Failure to adequately assess and manage medical conditions, regardless of reason, is not in the best interest of the patient. Literature and research studies have confirmed the disparities in health care among racial and ethnic groups. "In 2001, Hispanics of all races experienced more age-adjusted years of potential life lost before age 75 years per 100,000 population on non-Hispanic whites for the following causes of death: stroke (18% more), chronic liver disease and cirrhosis (62%), diabetes (41%), HIV disease (168%), and homicide (128%); in 2000, Hispanics had higher age-adjusted incidence of cancers of the cervix (152% higher) and stomach (63% higher for males and 150% higher for females) [41]." hospitalization rates for asthma are three times higher for blacks and 1.8 times higher for hispanics. black death rates are four times higher [42]. for hispanics, the rate is twice as high as compared to whites. hispanics had a rate of new aids cases over 3.5 times higher than non-hispanic whites [43]. "socioeconomic factors (e.g., education, employment and poverty), lifestyle behaviors (e.g., physical activity and alcohol intake), social environment (e.g., educational and economic opportunities, racial/ethnic discrimination, and neighborhood and work conditions), and access to preventive health-care services (e.g., cancer screening and vaccinations) contribute to racial/ethnic disparities [43]." these statistics are based on facts; the statistics on many documented and most undocumented hispanic populations are unknown. one can assume that if the situation is as bad nationally as it is with african american, native american and hispanic citizens, the situation with the many documented and most undocumented migrant farm workers must be even worse.

It is clear, after reviewing these statistics and identifying the biases and stereotyping that exist in the medical profession, that disparities in U. S. health care expose minority patients, especially the undocumented migrant farm workers to unnecessary risks, including possible injury and even death. Physicians have a moral responsibility to do what is good for their patients. Should a physician be impeded in the exercise of his or her reason and free will because of prejudice or bias on the part of the medical establishment, then that physician has an ethical responsibility to overcome that impediment and do what is demanded by the basic precepts of medicine—seek the patient's good. Hospitals also have a responsibility to their communities. If hypertension, diabetes, obesity, TB and HIV/AIDS are major issues in the undocumented community of people that a particular hospital serves, then it is the ethical responsibility of hospital administrators and health care professionals to formulate programs that address this immediate need. Failure to recognize prejudice and bias is a failure not only of the test

of beneficence; it may also be a failure of the test of nonmaleficence.

JUSTICE

This principle recognizes that each person should be treated fairly and equitably, and be given his or her due. The issue of medical disparities among minorities and especially among the undocumented also focuses on distributive justice: the fair, equitable, and appropriate distribution of medical resources in society. At a time when reforming healthcare in this country has become a high priority, failure to initiate preventative measures that would save medical resources in the end violates the principle of distributive justice. The justice principle can be applied to the problem under discussion in two ways.

Inequality concerning adequate health care for Americans is a well-documented fact. For years this inequality was attributed to socioeconomic causes resulting in a lack of access to care. With the publication of the 2002 IOM report, however, it is apparent that subtle racial and ethnic prejudice and differences in the quality of health plans are also among the reasons why even insured members of minorities sometimes receive inferior care. Prejudice and negative racial and ethnic stereotypes may be misleading physicians and other health care professionals. Whether such bias is explicit or unconscious, it is a violation of the principle of justice. It has been documented that members of minority groups are not receiving the same standard of care that whites are receiving, even when they have the same symptoms. One example is a 2007 National Healthcare Disparities Report finding that for Hispanics, 80% of core access to healthcare measures has either remained unchanged or gotten worse [$_{43}$]. the report also found that being uninsured has a large negative impact on the quality of health care individuals receive. uninsured individuals are about six times as likely to lack a usual source of care and four times as likely to be without a usual source of care for financial reasons. uninsured individuals are nearly three times as likely not to get care as soon as wanted for illness or injury, over twice as likely to not have a mammogram (for women over 40), and over twice as likely to have communication problems [$_{43}$]. all of these statistics can be applied to the undocumented migrant farm worker population and the rates will probably be even higher. “for hispanics in the united states, health disparities can mean decreased quality of life, loss of economic opportunities, and perceptions of injustice. for society, these disparities translate into less than optimal productivity, higher health care costs, and social inequity. by 2050, an estimated 102 million hispanics will reside in the united states, nearly 24.5% of the total u.s. population. if hispanics experience poorer health status, this expected demographic change will magnify the adverse economic, social, and health impact of such disparities in the united states [$_{43}$].” this is a blatant disregard of the principle of justice.

The principle of justice also pertains to the fair and equitable allocation of resources. It has been documented that members of minorities are less likely than whites to be given appropriate cardiac medicines or undergo coronary bypass surgery. Minorities are less likely to receive kidney dialysis, kidney transplants, or the best diagnostic tests and treatments for cancer. Minorities are also less apt to receive the most sophisticated treatments for HIV and diabetes. As of 2002, the total cost of diabetes in the United States (direct and indirect) was $132 billion. Direct medical costs were $92 billion, indirect costs (related to disability, work loss, premature death) was $40 billion. The average annual health care costs for a person with diabetes are $13,243, whereas the average annual health care costs for a person without diabetes is $2,560 [$_{44}$]. if african americans and hispanics are twice as likely to die from diabetes than whites, in many cases because of a lack of adequate medical treatment, then the principle of distribute justice would dictate that programs should be implemented to screen, assess and treat hispanics and other minorities, especially the undocumented migrant farm worker population, not only for their benefit but also to benefit society as a whole.

We Americans espouse the belief that all men and women are created equal. Equality has also been a basic principle of the medical profession. If we truly believe in equality, we should insist that all men and women must receive equal medical treatment and resources. Denying certain minorities medical treatment, when whites receive them as a standard of care, is an unjust allocation of resources and violates a basic tenet of justice. Physicians and the medical profession have an ethical obligation to use available resources fairly and to distribute them equitably. Failure to do so is ethically irresponsible and morally objectionable. To compromise the basic ethical foundations upon which medicine stands is destructive not just to minority patients but to society as a whole.

CONCLUSION

To address these medical and ethical concerns, this comprehensive education and prevention model has been

created to meet the needs of the migrant farmworkers in southern New Jersey. The Health Promoters Program is an initiative whose foundation is based on an established program in the third world, which has not only increased medical care in these areas but has also saved countless lives. As the undocumented population continues to increase in the United States, and health care costs continue to skyrocket, this new initiative can become a paradigm for all hospitals in the United States. Racial and ethnic disparities in health care constitute a complex issue that pertains to individuals, institutions and society as a whole. Unless we address these disparities and begin to eradicate them, America will never attain the goal of equitably providing high-quality health care in the United States for all residents. The Health Promoters model will not only save valuable medical resources; it will also save precious human lives.

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