

## SPECIAL ARTICLE

### DELIVERY OF PRIMARY HEALTH CARE — UNION STYLE

#### A Critical Review of the Robert F. Kennedy Plan for the United Farm Workers of America

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**Abstracts** The primary health-care program developed by the United Farm Workers of America, an example of a consumer-controlled system, provides quality health care at locations and time convenient to patients and employs bilingual clinic personnel from the same worker background to bridge the cultural gap between provider and consumer.

By combining health-care delivery with union activities, it has been possible to finance the system

through grower contribution by contract and to alter unhealthy working and living conditions on the farms. However, the lack of decision-making power by the health workers has resulted in poor working conditions and a high turnover of personnel.

Complete consumer control has built into it the same hazards as complete professional control, and some balance of power is clearly necessary if the needs of both are to be adequately met. (N Engl J Med 294:641-645, 1976)

AS legislation toward some form of national health insurance receives increasing attention, it is important to examine the strengths and weaknesses of different approaches to the delivery and financing of primary care so that something can be learned from the successes and failures of others. Such an investigation is particularly important when the care system involves a considerable proportion of consumers from a socioeconomic or cultural background that differs from those of the planners and providers.

The purpose of this paper is to examine one health system that has a number of unique features, in terms of the financing and delivery of care to a migrant Spanish-speaking farm population and the personnel practices developed by a consumer-controlled board of directors. This is the health program developed by the United Farm Workers of America, called the National Farm Workers Health Group.

There are about 300,000 farm workers in California. This population has been a particularly difficult one to provide health care for because of low income levels, crowded and often unsanitary living conditions, geographic mobility, lack of fluency in English, and a cultural background (largely Mexican but also Filipino, Arabian, Portuguese and others) that differs from the majority of the people in the health-care system.<sup>1</sup> Given these characteristics, and a type of work that exposes its members to a number of chemical toxins as well as requiring difficult physical labor, it is not surprising that this group experiences a higher than average level of morbidity and mortality.

To understand some aspects of the care system worked out for a segment of this population by the United Farm Workers, it is necessary to understand something about the union itself, for the two are intimately intertwined.<sup>2,3</sup>

Efforts to form a farm worker's union were begun by Cesar Chavez in 1962. The United Farm Workers won their first contract in 1966 after a merger with the Agricultural

Workers Organizing Committee of the AFL-CIO, a strike of grape vineyards, and the formation of a national boycott of California table grapes. The Union's strength peaked in 1969-1970, when over 60,000 workers were picking under United Farm Worker contracts. In 1973 many of the growers arbitrarily switched contracts to the Teamster's Union without holding worker elections, and the number of workers under UFW contracts dwindled to about 10,000. This development led to another series of strikes, a reactivation of the national boycott for grapes, lettuce, and Gallo wine, and a series of protest marches, such as the one to Modesto, in which over 20,000 people took part.

In 1975 the California legislature passed a law requiring union representation to be determined by a secret ballot of the workers on each farm. These elections are currently being held, and preliminary results indicate that the union will regain at least some of its lost strength.

The union health plan came into being during the time from 1969 to 1973, when the union was at the peak of its membership.<sup>4</sup> As can be seen from the following statements from union literature describing the philosophy of the plan, the health program was always conceived as being part and parcel of union activities and not a separate entity in and of itself:

"People are healthy not because of good hospitals or good doctors, or good medicine. Healthy people are a product of a healthy life. A healthy body demands that you have decent living conditions and decent working conditions."... "A strong contract is of much more value to the health of you and your family than a dozen clinics."... "Healing bodies while simultaneously healing the social ills that create conditions causing illness is truly a revolutionary and innovative approach to preventive medicine." In other words, the health plight of the farm worker is seen as "a symptom of poverty and powerlessness" rather than as a separate entity by itself.

The health plan started from the same basic premises used to develop the union: "We started with two principles: First, since there wasn't any money and the job had to be done, there would have to be a lot of sacrificing; second, no matter how poor the people, they had a responsibility to help the union."

These principles were put into action first in the decision

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that the health program would have to be self-supporting and not rely on any government subsidies or grants, since so many of the programs started in this way collapse or are badly crippled when the grant support runs out. To this end, all union contracts were written so that the growers agreed to contribute 10 cents per working-man hour into a health fund. Secondly, the benefits were worked out with the workers themselves. Possible health services were listed and put on different-colored cards along with an estimate of how much of the 10-cent contribution it would take to provide the service. A series of meetings were held with the workers at different ranches, and they were asked to select from these cards the best combination of services that could be purchased for the 10 cents. After this selection was made by several hundred workers, the most frequently selected items were combined into a health program and named the Robert F. Kennedy Health Program.

Although hospital coverage was desired, it was obvious that it would take too much of the available funds, so that the highest priority was given to preventive and early curative services. The package included prenatal and postnatal care, well-child care, periodic screening and health examinations, acute-illness care, health education and follow-up care for people with chronic illnesses and outreach services to the different farms. In addition, a death benefit was selected to help pay funeral costs. Worker eligibility for these services depended on the amount of time worked under a union contract.

The original idea was to purchase these services from outside providers, but continuous problems led to the formation of clinics run by and for the union. Some of the problems that led to this decision were inconvenient hours and location of health services, lack of Spanish-speaking personnel and understanding of the Mexican culture, the reluctance on the part of some providers to accept patients paid for under this plan, a tendency by others to overcharge for their services, and the generally impersonal way in which even adequate care was delivered. Finally, none of these providers offered anything in the way of health education or outreach services.

These deficiencies led to the formation of the first farm workers clinic in Delano in 1970. This development, in turn, was followed by the opening of the Calexico Clinic in the Imperial Valley in 1971, and clinics in Sanger and Salinas in 1973 (Fig. 1).

The clinics were financed largely through the Robert F. Kennedy Health and Welfare Fund, which received the 10 cents per working-man hour contributed by the grower for each person working under a union contract. Leroy Chatfield, administrator of the fund, reported 55,000 worker cards in the files in the summer of 1971; the fund was then disbursing \$60,000 a month in medical benefits that ranged from \$5 for a visit to the doctor's office, up to \$300 for maternity benefits and \$400 for surgical procedures. Members had to work 250 hours per quarter to qualify for major benefits, but only 50 hours a quarter to qualify for the minor-benefit program. The plan was designed for workers who were without employment for weeks at a time, in contrast to many commercial insurance programs for farm workers.<sup>3</sup>

### CLINIC OPERATION

The operation of the clinics varies somewhat according to location, the number of union contracts in the area, the number and type of personnel available, and the rise and fall of union fortunes in general. The clinics themselves are located close to the farms where the people work and are open from about 10 a.m. to 7 p.m., so that the workers do not have to miss a day's work to be seen. Most of the personnel working in the clinics are bilingual, and many are from farm-worker families and have received on-the-job training.

One of the key positions is the family health worker. These people do much of the initial screening and triage of patients presenting problems, translate for health personnel who are not yet bilingual, find out what is going on at home that may be related to the patient's health problems and provide health education to pregnant mothers, mothers of new babies, and people with chronic diseases. They also act as health advocates by helping people fill out disability forms, getting the patient to the proper agency or consultant's office and helping the patient negotiate the red tape involved in being seen in an emergency room or hospital clinic. Initially, family health workers carried out many of these activities in outreach clinics in places such as Head Start Centers. As the union became embroiled in the turbulence of 1973, the focus was shifted to provide care on the strike lines and to workers jailed for trespass.

Another activity of the family health workers has been to gather data on the crowded unsanitary living conditions that are seen where the workers live, and these statistics have been used to jog legislators and health-department officials into improving and enforcing the environmental sanitation codes. Most of the family health workers have had

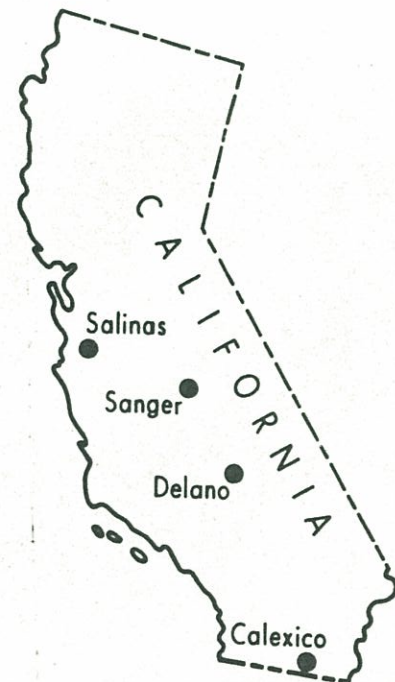


Figure 1. Locations of National Farm Worker Health Group Clinics.



little formal education but are doing an excellent job and form the backbone of clinic operation.

Other personnel have been recruited from people working on the national boycott. Some are former college students with little medical background who have been trained to screen emergency calls, provide first aid, and follow women in labor until near delivery before calling the physician. Finally, there are a number of nurses and physicians who have chosen to work the long hours at low pay because they believe in what the union is trying to accomplish.

The amount of effort used to blend traditional folk medicine with scientific medicine has varied from clinic to clinic, but this goal was regarded as important by the planners.<sup>6</sup> Some of the clinics have prescribed folk medicine for symptomatic treatment of nonserious illness instead of providing aspirin or phenobarbital.

One clinic actually employed a "curandera" (a lay healer) for several months. Since many of the problems seen in the clinic were chronic conditions such as musculoskeletal problems for which scientific medicine has no cure and that were frequently accompanied by emotional components as well, it was hoped that this person would add a dimension of care that would be more acceptable to many of the farm workers and better meet their needs.

Her procedure in seeing patients was to ask a few questions about symptoms, percuss the chest or abdomen, and prescribe a treatment consisting of some combination of massage, herbal medicine, or a "shot." She did, in fact, have a few dramatic successes with this approach. For instance, there was one worker who had been severely injured in a job-related electricity accident and, though physically recovered, was unable to work and kept arriving at the clinic with multiple vague complaints. The "curandera" prescribed a program of back manipulation and massage. When this treatment was completed, she told the man that he was cured and could return to work, which he promptly did.

However, several problems developed that ultimately led to her termination. Her role in the clinic was not clearly defined, and little orientation was given to the staff in why she was there and how best to make use of her services. Her "nonscientific" approach to patient care upset some members of the staff, resulting in one resignation. Severe diarrhea developed in several patients from some of her medicine. Finally, it was found that she was referring some of the clinic patients to her home for continued treatments at a higher fee than that charged in the clinic. In retrospect, these problems could have been avoided if her role as consultant on carefully selected problems had been made clear at the beginning and the staff had been adequately oriented in why she was there.

All the clinics do their own simple blood, urine, and culture tests, and buy standard medicines in bulk quantities — a system that allows them to be dispensed to patients at a cost considerably less than that found in a pharmacy. The largest clinic, at Delano, has its own x-ray facilities; babies are also delivered in a special area in this clinic. All the clinics perform vision and hearing screening, tonometry, electrocardiography and Denver Developmental Tests. Finally, each clinic uses the problem-oriented record

system, and records are kept in family folders so that all members of a family can be reviewed at the time of record audits.

#### RELATION TO UNION ACTIVITIES

As mentioned earlier, the activities of the clinic are intimately intertwined with the purposes of the union. Although originally open only to members of the Kennedy Plan, the clinics have recently been seeing nonunion members as well, because it was decided by union officials that this would be a good place to recruit new members. The waiting rooms are filled with union literature and posters, and patients are currently enlisted to sign authorization cards saying that they wish to have an election on the farm where they work and to be represented by the United Farm Workers Union. Some are asked to conduct house meetings in which they invite friends and neighbors over to tell them about the union and the coming elections. The house meeting has long been an important organizing tool of the union, and it is used effectively for health education at the same time.

Clinical personnel are expected to attend union meetings, participate in the boycott locally, walk picket lines, and deliver health care to jailed workers during times of stress. Another activity is to place pressure on local hospitals to provide more Spanish-speaking personnel. A description of how one nurse combined her health and union roles is available in a recent article.<sup>4</sup>

Health workers also participate in safety committees made up of growers and farm workers in equal numbers to discuss hazardous working conditions on the farms. Through efforts such as these, highly toxic pesticides such as aldrin, endrin, and dieldrin were banned in farm-worker contracts four years before the Environmental Protection Agency restricted the use of these poisons. Clauses have been written into contracts requiring growers to provide hand-washing facilities on the spray rigs so that workers will have an opportunity to remove pesticide residues. Other accomplishments of this committee include the identification and removal or repair of defective farm equipment and the provision of portable toilets in the field.

At times, union activities interfere with the operation of the clinics. Before the elections on the farms, the organizers, under tremendous pressure themselves, were putting pressure on the clinics to extend their working hours and take on a new load of nonunion patients to aid them in their organizing. Sometimes an organizer would arrive with a new nonunion worker with a chronic illness and expect him to be seen immediately, in spite of a full waiting room. At other times, patients who were often involved with specialists in another care system would be led to believe that the clinics could do better. These patients, and the organizers, were upset when the physician's first response was to try to encourage the person to return to his regular care system or to request that all the past records be obtained and reviewed before anything new was tried. This taking on of large numbers of new patients by a staff already too short of personnel did not do much to improve morale.



### EVALUATION

One way to evaluate this health-care system is to compare its operation with criteria set up by Saunders in his classic book describing what happens when a medical-care system dominated by members of one culture tries to deliver care to a people with different traditions and beliefs.<sup>5</sup>

After surveying the wreckage of a number of programs that failed to bridge the cultural gap, he makes a series of recommendations that he thought would be necessary for successful delivery of care to the Spanish-speaking people of the Southwest. Among these are delivery of care at a cost that can be afforded by those receiving the care. For this purpose he advocates government subsidy and avoidance of becoming top-heavy with specialists and specialist equipment, emphasis upon prevention and early recognition of illness, and liberal use of paramedical personnel and volunteers. The second recommendation is availability of services at convenient times and places and in settings that are familiar to the people served, with a minimum of middle men between the patient and the provider of care. The third consists of an education program for patients about how to make use of scientific medicine, a blending of folk and scientific medicine and an understanding by the providers of the value system of the culture involved. Fourthly, patient anxieties are minimized through explanation of unfamiliar equipment or procedures and respecting patient modesty. The fifth recommendation involves co-ordination of services with those provided by community agencies and serving as a patient advocate to help consumers use those services. The sixth is working with indigenous community leaders. The seventh entails asking the consumers to pay a fee for service rather than asking them to pay a monthly payment whether they are sick or well. The eighth advises personnel not to be too concerned about keeping appointments since the culture has always emphasized the present with less concern for the future. Finally, a minimum of requests is set up for consumer participation on boards, attendance at meetings, and other activities that are not part of their cultural tradition. The union has put almost all these recommendations into practice.

### ACCEPTANCE BY CONSUMERS AND VIABILITY

Acceptance can be indirectly assessed by the frequent use made of the clinics by the workers and their families and by such things as the almost daily appearance of a worker at the door with a basket of tomatoes, nectarines or grapes for the health personnel. Many of the frequent clinic users are on a first-name basis with the health professionals, and a feeling of pride in the program frequently surfaces at union gatherings and in union publications. Finally, the fact that all four clinics are still in operation, in spite of severe restriction of funds from loss of contracts during 1973, attests to the viability of the program in hard times as well as good.

The union is also a pioneer in some aspects of preventive care. By including health education and outreach costs into its medical insurance program, the union can pay for such services on an ongoing basis. Few, if any, other insurance programs include such services.

### PROBLEMS

In spite of the many accomplishments of these clinics, there are, as we see it, some major problems, which largely concern the working conditions of the health personnel. One of the basic themes that permeates the union is that of self-sacrifice, and, as can be seen from union literature, this principle applies to the health professional as well as to everyone else:

What we have we must share with others who are willing to struggle until all farm workers and their families enjoy the fruit of their labor and can lead a healthy life. Those unwilling to struggle have no place in the union. Those unwilling to sacrifice so that they might share their medical benefits with others have no place in our clinics.

The clinic staff must not rest until good health care is a reality for all farm workers and not just a hope.

People joining the union health program are asked to submit a budget of basic expenses including housing, transportation, and any debt obligations that need to be paid off. If approved, either these expenses are paid directly by the union upon the submission of a bill or a monthly sum is arrived at and the person pays his own bills. In addition, 38 liters (10 gallons) of gas a week, a basic food allowance of 10 dollars per week, per person, and five dollars a week for personal expenses are also provided. These rates are basically the same for all union workers, regardless of type of job performed or level of experience, and seldom result in a total salary of more than \$3,000 or \$4,000 a year. The food and basic living allowance has remained the same over the past years, in spite of rampant inflation. If a health professional or any volunteer becomes sick enough to require hospitalization, he or she is expected to go on welfare, since there is no provision in the budget for such illness.

In addition to the low pay, the working conditions are demanding. The particular clinics in which we worked listed hours from 10 a.m. to 7 p.m. from Tuesday through Saturday, and 2 p.m. to 7 p.m. on Mondays, with someone on call for emergencies at other times. In practice, one rarely leaves the clinic until after 7:30 or 8:00 p.m. because of an influx of late patients, and the need by the clinic personnel, including the doctor, to mop the floors and ready the clinic for the next day. By the time the evening meal is completed at 9 p.m. or later, there is essentially no time to pursue outside interests. In addition, there are one or more union meetings to attend per week in off hours, and hospital rounds are usually made in the morning, before clinic opening. No provision is made to stagger personnel so that some could get off occasionally on a rotating basis. The basic theme is that those who do not willingly work such long hours are not truly dedicated to the union cause. Currently, there is a shortage of physicians, with only one physician at three clinics and two at the largest clinic. Because of the shortage of personnel and lack of funds, vacations are not taken readily, and some staff members have less than a week per year away from the job. After-hours coverage varies, from nurse practitioners or paramedical personnel screening out non-emergency calls, in some clinics, to the doctor receiving every call and performing this function, in others.

Other problems include no provision for postgraduate



education for the nurses or the physicians, and little ongoing educational programs for other staff members. Staff members are so busy providing primary and emergency care that there is little or no energy to pursue further education, leading to ingrained ideas and, sometimes, incompetent practices.

Also, the health personnel have little power to change the system. Major decisions affecting clinic personnel and methods of operation are made by a board of directors for the union, on which no one with a health background or a strong identification with the health personnel sits. The person representing the clinics to this board has no health background and often responds to requests for changes by questioning the dedication of the person making the request, rather than in a constructive fashion. Therefore, although the clinics have been set up to meet the needs of the consumer, and are doing a good job, they are not meeting the needs of many of the providers of care, and this is a major weakness. It is not surprising, then, that there has been a large turnover in personnel. For instance, out of the 15 doctors recruited for the program, only four remain, and two have been in the program less than one year. A similar turnover has been in evidence for the nursing personnel and family health workers. Many of the latter have had to leave during a family crisis to obtain a better-paying job or one that allows them to work part time. One nurse had to leave the program because the union would not pay for her child-care arrangements while she was working.

Even the most dedicated persons tend to burn out in a year or two under these conditions. In this respect, of interest is the observation of two clinic nurses who had been medical missionaries in Africa for a number of years before working for the union. They commented that the Church had started out this way but had to change its policies because of the high morbidity and departure rate of even the most dedicated personnel.

Lack of dental care is one obvious gap in service: not even a dental hygiene program is included. Other personnel, such as nurse midwives, mental health services, and physiotherapy services would add much to the program. More family health workers are needed in some of the clinics to maintain adequate cultural balance and provide the education and outreach services that are so important for a truly preventive approach to health care.

Finally, another potential problem is that health claims are reviewed by a worker-elected committee at the local ranches. Although this process does much to educate personnel about the workings of the plan, it also presents an important problem around confidentiality of records.

### DISCUSSION

The clinics have successfully bridged the cultural gap and are delivering a brand of medicine of relatively high quality in a manner acceptable to and under the control of the consumer. However, the complete lack of power of the health professionals has resulted in working conditions that lead to an extremely high turnover of health personnel and keep the clinic operations in a perpetual state of crisis.

What about the future? Perhaps some of the financing problems will be solved when the union gets more contracts as the result of recent elections. On the other hand, it seems clear that to gain more adequate working conditions, the health professionals need to organize and demand from the union some of the same conditions of employment that the union is demanding from the grower: "...to have healthy working conditions, to live in dignity and be paid fairly for our work and to have control over our lives...and time to enjoy life."

Complete consumer control has built into it the same hazards as complete professional control, and some balance of power is clearly necessary if the needs of both parties are to be adequately met. Only the future can tell whether or not the union and other planners of health care will recognize and act on this basic principle.

We are indebted to the many persons working in the clinics who freely gave their time to answer questions about the clinics and explain union policies.

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