HEALTH AND THE BORDER REGION

Analysis to inform funders, policymakers, and stakeholders on the health disparities and needs among those living and working in Border communities.

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BORDER PHILANTHROPY PARTNERSHIP
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The U.S.-Mexico Border Philanthropy Partnership serves as the leading binational organization focused on building prosperity along the U.S.-Mexico Border region through leadership, collaboration, and philanthropy.

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INTRODUCTION

We believe that the challenges and opportunities across the Border region demand informed civic participation, strong leadership and cross-border understanding, and collaboration.

For generations, the Border region between Mexico and the United States has been transformed from a lightly populated geographic area to a dynamic enterprise zone with a booming economy and population. Today, substantial numbers of residents on both sides of the Border interact on a daily basis, producing a society and geographic territory that is different from the rest of the United States and Mexico.

However, the border contrasts a highly-developed, wealthy nation with a developing country and the issues are well known but persistent. Research indicates that if the region comprising the border across the 10 states – Mexican and American –were America's 51st state, it would rank at or near the bottom in nearly all measures of prosperity, community health, educational opportunity, and quality of life. Further, negative stereotypes about the border region are widely held throughout the United States and Mexico, and they frustrate possible solutions for many border issues and justify imposition of federal and state border policies and programs, often without adequate input from local stakeholders and often accompanied by unintended consequences.

This Border Brief, which is one in a series, highlights issues and offers critical insight to drive new solutions. It is our desire that this information will help foster greater philanthropic and corporate support, as well as our nonprofit partners to carry them out to address the need for coordinated philanthropic leadership, cross-cultural understanding, and public policy advocacy. The Border Briefs provide current and accurate information about health, environment, education, migration, philanthropy, and general Border dynamics.

SECTION TWO

BORDER POPULATION AND MIGRANT FLOWS

By 2015, the U.S. Border population was 7.9 million and Mexican population was 7.2 million.[1] Some 97 percent of the U.S. Border population was concentrated in nine urban counties and 11 Mexican urban municipalities contained 85 percent of Mexican Border population. Most Border population was in twin city pairs along the Border that form binational metropolitan urban areas. Although urban areas have many problems, employment opportunities are concentrated there and provision of health, education, and cultural services is more efficient. Border urban areas also are the preferred destination of domestic and international migrants.

The flow of people back and forth across the Border is extraordinary. People cross in both directions for work, for recreation, for shopping, for education, and for services, including health care needs. In 2022, there were 167.2 million northbound crossings along the U.S.-Mexican Border, which was below pre-pandemic levels of 188.2 million in 2019 and 293.1 in 1999. Northbound crossings in 2022 included 46.0 million at San Diego, 18.1 million at El Paso, and 10.1 million at Brownsville. Infectious diseases cross the Border in both directions along with people. The outbreak of the H1N1 influenza pandemic, commonly called swine flu, in Mexico in March and April 2009 and its rapid spread to the Border and other locations in the United States highlighted the need for close cooperation between Mexican and U.S. authorities.[2] Disease-resistant tuberculosis and measles are communicable diseases that along with COVID-19 have recently been of concern in this very dynamic region.

> *Numerous Border residents access health care on both sides of the Border but health care systems are poorly coordinated across the Border and are not well prepared for significant Border emergencies such as pandemics.*
>
> Paul Ganster, Ph.D.

SECTION THREE

BORDER HEALTH CONCERNS

Some aspects of the health of binational Border residents have improved over the last several decades, but serious concerns still exist. The U.S. Border has health disparities within the region and when compared to state and national averages. The Border region is one of the poorest areas of the United States, similar to areas of the deep South and parts of Appalachia.[3] At least ten percent of Border inhabitants are underserved in terms of water and wastewater infrastructure, problems that are associated with infectious diseases and chronic health conditions.[4] The Mexican Border region demonstrates significant disparities internally and when compared to the U.S. Border region. Measuring changes in the health of the binational Border population is complicated by the lack of comparable U.S. Border county and Mexican Border municipal data that are regularly compiled, updated, and made available by government agencies, despite calls for harmonized health data that go back many decades.

Infant mortality is an important health indicator for it reflects factors such as access to pure water and sewage disposal, income levels, and health care availability. The US-Mexico Border Human Development Index[5] shows that from 1990-2015 infant mortality in Mexican Border municipalities declined from 24.0 deaths per 1,000 live births to 11.4, a remarkable improvement with better outcomes than Mexican Border states and the nation. The U.S. Border counties improved from 14.9, which was worse that the nation and the Border states, to 4.5 in 2015, which was better that both the Border states and the nation. However, the infant mortality rate in Mexico's Border municipalities was more than 2.5 times that of U.S. counties, reflecting general crossborder Border asymmetry and health disparities. The improvements in infant mortality for the Border counties and municipalities were probably the result of major investments in water and wastewater infrastructure by U.S. and Mexican federal and state agencies in cooperation with the North American Development Bank beginning in the late 1990s. Texas, the location of most of the Border's colonias also invested heavily in basic infrastructure for those undeserved communities. Expansion of community clinics along the Border also boosted infant and maternal health.

Source: Healthy Border 2020

What are the health problems at the Border?	Categories	Causes and/or determinants
• Obesity • Diabetes • Heart Disease • Asthma	Chronic and Degenerative Disease	• Physical inactivity • Poor diet (high caloric intake) • Poverty • Genes (non-modifiable determinants) • Lack of breastfeeding • Education / access to information
• Tuberculosis • HIV / AIDS /Sexually Transmitted Infections • Acute respiratory infections • Acute diarrheal disease • Vaccine preventable diseases (pertussis, measles, and Hepatitis B)	Infectious Disease	• Poverty • Inadequate nutrition / poor nutrition • Internal / external migration • Environmental health (water, sewer services) • Access to health education / information • Access to health care and delivery • Poor living conditions / poor hygiene (personal, housing)

The Healthy Border 2020 initiative of the United States-Mexico Border Health Commission (USMBHC) outlines priority health concerns and causes of diseases in the binational Border region based on 2000-2010 data analysis.[6] These are listed in the accompanying table and indicate the most concerning Border health issues.

Border health authorities also are concerned about maternal and child health, mental health, drug and alcohol abuse, and injury and death from accidents and violence. Drug trafficking in the Border region has a huge impact on Borderlanders through addiction and drug overdose that has been exacerbated by cartels lacing drugs with fentanyl. Narcotrafficking-related violence and crime has caused very high homicide rates in Mexican Border cities as well as increases in kidnapping, extortion, and other crimes. Although U.S. Border cities tend to have low crime rates and are among the safest in the nation, there is an increasing societal toll from drug overdose deaths and drug related crime. The insatiable demand for illegal drugs in the United States drives the system of crossborder drug trafficking, money laundering, and illegal firearms sales to Mexico that negatively impact both societies.

"Many of these health problems are deeply rooted in poverty on both sides of the Border."

Mexican Border municipalities, for example, in 2015 had more than 2.5 million people or 31.1 percent of the population in poverty.[7] In 2019 more than a quarter of people in U.S. Border counties were considered high-risk to impacts of natural disaster, based on factors such as income, age, and health insurance.[8] Some diseases such as asthma are linked to bad air quality in many binational urban and rural air basins. Low-income areas around ports of entry are especially problematic. Private vehicles and heavy-duty diesel cargo trucks spew contamination while waiting to cross the Border and while using access roads to and from the ports of entry.[9]

SECTION FOUR

HEALTHCARE SYSTEMS

The U.S. health system is a mix of public and private for-profit and nonprofit insurers and health care providers. In 2021, private plans that were mainly employment-based covered 66 percent of the population, 35.7 percent were covered by public plans such as Medicare, Medicaid, and Veterans Administration funded by the federal government, and some 8.3 percent were uninsured.[10] Public and private insurers set their own benefit packages and cost-sharing structures within federal and state regulations.[11] Uninsured or underinsured Border residents use free community clinics supported by government funding and community-based organizations or hospital emergency rooms that are required by law to provide care. Despite improvements over the last several decades, many uninsured residents of the U.S. Border do not have adequate access to care. Health care facilities as well as health care professionals are frequently in short supply in poorer Border communities.

In Mexico, health insurance and services are mainly provided by social security systems related to employment such as IMSS for workers in the private sector, ISSSTE for federal government workers, PEMEX, and the military as well as by several state systems.[12] Private health insurance covered less than 3 percent of the population in 2020. Health services for uninsured were provided from 2004 by Seguro Popular, which was replaced in 2020 by the Instituto de Salud para el Bienestar (INSABI) that was replaced in 2022 with IMSS-Bienestar, a decentralized public agency of the Mexican Social Security Institute, was tasked with developing a replacement system.[13]

Theoretically, every person in Mexico who does not have health insurance has the right to free care in public clinics and hospitals. However, budgets are inadequate and administration challenges result in drug shortages, staff shortages, and long wait times. Most people at some point turn to private providers or pay directly for medicines or supplies even when visiting a public facility. Private clinics are one option, but many lower income Mexicans use clinics adjacent to private drugstores that now serve perhaps 20 percent of the population. For example, the private pharmacy-clinic chain Farmacias Similares has some 8,500 pharmacies and the number is increasing rapidly, providing low-cost generic drugs and convenient services to many working Mexicans.[14]

U.S.-MEXICO BORDER PHILANTHROPY PARTNERSHIP

The U.S.-Mexico Border Philanthropy Partnership is made up of more than 400 members from academia, business and corporate entities, government, philanthropy, and nonprofit organizations spanning all regions of the U.S. and Mexico. Together, we share a common vision and commitment for a thriving Border region.

Opportunities for better coordination of health services across the Border exist. For example, Medicare does not pay for services outside the United States. However, reimbursing for services in the Border region of Mexico would improve health care services for covered patients and reduce costs to the Medicare system by paying lower rates south of the Border.

opened in 1993 and that of Arizona the following year. These reflect the growing Border population and Border economic expansion as part of the North American Free Trade Agreement. San Diego County opened its Border health office in 1997 and Imperial County followed in 1998. Arizona and New Mexico also have county offices of Border health and Texas serves its many Border

16.8% *In 2019, U.S. health expenditures* **5.4%**
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There is substantial asymmetry between health care expenditures of the two countries. In 2020, public and private per capita health expenditure in the United States was $11,859.20, more than nine and one-half times that of Mexico at $1,226.70.[15] In 2019, U.S. health expenditures were 16.8 percent of GDP and Mexico's were 5.4 percent of GDP.[16] It should be pointed out that health outcomes in the United States are surprisingly poor given the huge health expenditure. The portion of health expenditures from public sources (government transfers and social insurance contributions) in 2019 according to OECD data was 50 percent for Mexico and 51 percent for the United States, both well below the OECD level of 71 percent.[17] The expenditures for U.S. Border counties are likely below the national average, while for Mexican Border municipalities they are probably above the national average. The Texas, New Mexico, and California state offices of Border health

counties with four regional health offices. Mexican Border states have health secretariats with offices in the main Border population centers. Some Mexican Border state systems manage hospitals, clinics, and specialty health centers and some of these will be transferred to federal management.

At the local level on both sides of the Border, a web of public agencies, academic centers, community-based organizations and foundations, companies, and other entities cooperate with public agencies on matters of community health.[18] The non-governmental organizations are often able to respond more quickly to health care emergencies along and across the Border than federal and other government agencies that can be hindered by bureaucratic inertia, as the COVID-19 pandemic that hit the Border early in 2020 demonstrated.

SECTION FIVE

COORDINATING PUBLIC HEALTH

The two national healthcare systems have cooperated across the Border for many decades in response to infectious diseases and other health conditions in the transborder region, including mental health issues related to violence and the pandemic. Public health authorities address mutual concerns through sharing of information and collaborating on programs such as the Binational Border Infectious Disease Surveillance Program (BIDS).[1920]

The Pan American Health Organization (PAHO) established a field office in El Paso in 1942 as part of World War II binational collaboration, and the following year the U.S.-Mexico Border Health Association was formed.[21] By 2014, both organizations had ended operations, but for decades they provided critical communications regarding evolving health issues of the U.S.-Mexican Border. In 1997 Congress authorized funding, but not until 2000, however, was the U.S.-Mexico Border Health Commission (USMBHC) created by the U.S. secretary of health and human services and the secretary of health of Mexico. The commission initially did bring U.S. and Mexican federal health authorities together with the health departments of the ten Border states and local entities to address critical health issues of the Border region. The binational commission undertook over 30 specific strategic actions directed at improving the health of Border communities. It established priority goals for improving binational Border health and evaluated progress periodically, identifying areas of special concern. The USMBHC helped strengthen networks of cross-border health professionals, established a Binational Infectious Disease Initiative, and facilitated health referral systems in Mexican consulates in the United States. However, the U.S. section of the commission was defunded by the U.S. congress and administration and ceased operations in 2014 although the Mexican section has moved forward with programs, filling a leadership vacuum. The U.S. section activities were transferred to CDC where its excellent reports and studies have disappeared from the CDC website.[28] The failure to support this binational commission left government health agencies in the Border region unprepared to coordinate a proactive and effective response to the pandemic of 2020.

SECTION SIX

COVID-19 PANDEMIC

The COVID-19 pandemic arrived in the Border region early in 2020 and continued in 2023, exposing deficiencies in transborder health governance and coordination.[23] Rather than federal, local, and state governments uniting in a joint response for the binational emergency, the two sides of the Border followed different paths. Local, state, and federal governments on both sides of the Border avoided taking responsibility for the transborder region in favor of their own defined jurisdictions to address the pandemic. Robust and timely coordination for a regional governmental approach across the Border was lacking, despite decades of cross-border cooperation on a range of issues. Mixed messages from the two federal governments provided little leadership to local governments. Despite repeated warnings about pandemics and the Border, the two federal governments simply failed in their responsibilities to address concerns and realities of the region. Federal policies were imposed on Border crossings without proper health or scientific information or local input and often had unintended consequences. For example, essential workers such as farmworkers were forced to wait in long lines while crossing the Border during the pandemic, local retail establishments in U.S. Border communities were devastated by the disappearance of customers from Mexico, and the flow of food aid and pandemic supplies from U.S. sister cities slowed to a trickle. Preparation for the next major health emergency that affects the Border region should be a priority of Border, state, and national healthcare agencies. The pandemic enfeebled transborder ties and relationships that had evolved over the past three decades.[24] Effective transborder pandemic response instead came from the non-profit, civil society, and private sectors that quickly organized donations of medical supplies as well as food for growing number of unemployed in the region. Philanthropy, the private sector, and academic institutions, working with local consulates, also stepped up to overcome Border barriers and facilitate vaccinations for Mexican workers.[25] Throughout the Border region, the pandemic challenged healthcare systems to meet community needs. Large numbers of U.S. expatriates who lived in Mexican Border cities—approximately 300,000 in Mexicali and 200,000 in Tijuana, for example—crossed the Border for health services.[26] Access to routine health services was reduced as resources were dedicated to COVID-19 cases. Hospitals were overwhelmed and COVID-19 patients were sometimes turned away or attended in temporary structures. Medical equipment, including ventilators and ordinary sanitary equipment such as gowns and masks were in short supply.

The policy of Border closures and interruption of asylum application procedures forced many migrants to remain in Mexico for longer than expected, many in crowded shelters, camps, and other spaces unsuitable for long-term residence. The instructions of the Centers for Disease Control (CDC) in the U.S. rarely coincided with those of the Mexican Ministry of Health. The epidemiological data were not easily comparable across the Border and may have contributed to the confusion of the public about relevant measures, which made it more difficult to control the epidemic. As an example, at some point the health authorities of the two countries gave divergent messages regarding the use of masks. The requirements regarding social distancing were different across the Border; restaurants reopened in Tijuana while they remained closed in San Diego. This may have spurred people to cross the Border to enjoy recreational services with the consequent increased risk of contagion.[27] Ongoing evaluation of excess deaths in the region during the pandemic may better document the consequences of poor coordination of federal authorities across the Border. retail establishments in U.S. Border communities were devastated by the disappearance of customers from Mexico, and the flow of food aid and pandemic supplies from U.S. sister cities slowed to a trickle. Preparation

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SECTION SEVEN

CROSSBORDER USE OF HEALTH SERVICES

For many decades, Border residents have accessed health services on both sides of the international boundary. Wealthy Mexicans are able to access specialized medical services available in the United States and this highlights issues of health disparities south of the Border. The high cost of health care in the United States drives many people south of the Border in search of dental services, pharmaceutical drugs at a fraction of their price in the United States, and other medical services, including cosmetic surgery, eye surgery, primary health care, and alternative cancer therapies not available in the United States. Many U.S. Hispanic Border residents prefer to access services in Mexico with Spanish-speaking health care professionals.[29]

Border towns such as Algodones in Baja California many decades ago initially provided low-cost dental service to thousands of visitors from the northern U.S. states and Canada who wintered in nearby Imperial Valley and Yuma region. By 2000, these "snowbirds," often on fixed incomes, were able to find not only dentists in Algodones but optometrists, dozens of pharmacies, and even primary care physicians—all advertising their services with English-language flyers, signage, and even billboards on nearby highways. Another Border "dental oasis" is Nuevo Progreso, Tamaulipas, located on the Rio Grande / Río Bravo, that markets to the thousands of south Texas winter visitors. Large Border cities such as Tijuana, Mexicali, Nogales, Ciudad Juárez, or Matamoros provide even more health care options to crossborder clients.

Employers in the U.S. Border cities recognized the realities of transborder health services, and by the late 1990s some were offering binational health-care plans so that their workers and families could access health care in either the U.S. or Mexican twin city. In San Diego, for example, some companies have workers who reside in Tijuana with their families, and the transborder health coverage provides better service to the families and savings to the company.

Tijuana's New City Medical Plaza and other medical tourism facilities

SECTION EIGHT

HEALTH TOURISM

Mexican Border cities and investors have stepped up efforts to attract medical tourists from the United States as part of the booming world-wide medical tourism industry.[34] Many of these efforts are supported by Mexican regional and state economic and tourism development departments. The shocking cost of health care in the United States and millions of Americans who cannot afford health insurance or who wanted medical procedures not covered by insurance has created a lucrative market for lower cost medical care. Investors and local chambers of commerce in Border cities such as Ciudad Juárez and Tijuana have launched campaigns to grow the industry and attract more paying customers from north of the Border. In a few locations, medical services offered include advanced procedures such as cataract surgery, bariatric surgery, plastic surgery, and many other specialties. Some also function as a health maintenance organization (HMO), a model familiar to U.S. residents, on both sides of the Border at several locations along the Border. The senior care and assisted living industry has also attracted some investment in Mexico's Border region, but development has been slow.

Tijuana has seen significant growth of medical tourism in recent years.[35] Major investments in infrastructure include new high-rise buildings that house not only medical facilities but also luxury hotel rooms for recovery from medical procedures. The state government of Baja California has strongly supported this area of investment. Ciudad Juárez has a growing medical tourism sector, as do most Mexican Border cities.

Generally, medical regulation and oversight by the government is less strict and consistent in Mexico than in the United States. Cases in Mexico involving problems with unlicensed medical personnel performing procedures that went awry receive wide coverage in the U.S. media, contributing to concerns about quality of services. Recent studies that found Fentanyl and Meth-laced counterfeit pills that were indistinguishable from legitimate oxycodone or Xanax medicines were sold in Tijuana and Los Cabos pharmacies that cater to medical tourists, raising apprehension about safety of medical tourism in Mexico.[36]

In summary, Mexican health services play a crucial role in the transborder region since they have helped mitigate the impact of high-cost health care for U.S. Border residents. At the same time, the Border location is helping to develop and expand an industry that otherwise would not exist at the current level. So, the asymmetries and structural differences across the boundary created opportunities for the healthcare industry.

SECTION NINE

ACKNOWLEDGEMENTS

The U.S.-Mexico Border Philanthropy Partnership thanks its members and partners that provided grant support to complete this initiative.

ARCACONTINENTAL

CON ALMA HEALTH FOUNDATION

NEW MEXICO FOUNDATION
Healthy Entry for Asylee Lives (HEAL) Fund

Long Ridge Foundation

ARIZONA COMMUNITY FOUNDATION

SMARTBORDER COALITION

SENTRE

ABOUT THE AUTHOR

Dr. Paul Ganster is director of the Institute for Regional Studies of the Californias at San Diego State University. In 2022, he was honored with the Ohtli award, the highest recognition granted by the Government of Mexico to individuals who have opened pathways to Mexicans abroad, particularly in the United States of America.

Dr. Ganster is the author of numerous articles, chapters of books, and edited works related to Border regions. Recent publications include The U.S.-Mexican Border Today: Conflict and Cooperation in Historical Perspective (Lanham, MD: Rowman and Littlefield, 2016) and with Kimberly Collins, "Binational Cooperation and Twinning: A View from the US-Mexican Border, San Diego, California, and Tijuana, Baja California" (Journal of Borderlands Studies, 32:4, 2017). His ongoing research is on management of the binational Tijuana River Watershed, air quality at Border crossings, crossborder collaboration, the binational problem of used tires, and sustainable tourism in the peninsula of Baja California. He has been a Fulbright professor in Costa Rica and a visiting professor at the Autonomous University of Baja California in Tijuana. He received his bachelor's degree from Yale University and his doctorate from the University of California, Los Angeles. Ganster is chair of the Good Neighbor Environmental Board, a federal panel that advises the president and congress on the Border environment. He is also chair of the Committee on Binational Regional Opportunities (COBRO) of the San Diego Association of Governments (SANDAG). In 2016, he was recognized with the Association for Borderlands Studies (ABS) Lifetime Achievement Award. In 2017, the Autonomous University of Baja California awarded him the honorary degree of Doctor Honoris Causa for his scholarly work in the binational region and for his work linking UABC and SDSU. Also in 2017, Tijuana Innovadora recognized him in the induction ceremony to the Paseo de la Fama / Walk of Fame at the Palacio Municipal of Tijuana for his binational leadership.

Dr. Ganster received support from additional academic partners for this work, including Sergio Peña Medina, Josiah Heyman, and Kimberly Collins.

The Border Briefs were also made possible thanks to translation services provided by MaLaura Muñoz and design support from Justin Nunez.

SECTION TEN

ENDNOTES

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