

Shared Destiny: Shaping a Binational Agenda for Health Priorities

in the San Diego – Baja California Border Region



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Dr. Robert L. Bach: Bach is currently on the faculty at the Center for Homeland Defense and Security, Naval Postgraduate School, Monterey, California. Independently, he works as a consultant on homeland security, primarily involving border and transportation security issues, and community-based preparedness. Bach's research includes projects on migration, poverty and social vulnerability in Vietnam and other low income countries, and he serves as a strategic planner and policy advisor on educational development issues in the United States.

Earlier, Dr. Bach was Director of the Global Inclusion Division of the Rockefeller Foundation, where he focused on poverty and social exclusion in transnational and global issues. Dr. Bach also served as Deputy Director of the Foundation's Working Communities Division. From 1994 to 2000, Dr. Bach served in the Immigration and Naturalization Service at the U.S. Department of Justice as Executive Associate Commissioner for Policy, Planning and Programs. He worked extensively on border and international issues, especially with Mexico and Canada. Dr. Bach's scholarship concentrates on employment, immigration, national and human security and public policy both inside the United States and around the world. He was a professor at the State University of New York at Binghamton, earning his doctorate from Duke University. He graduated summa cum laude from the University of Pennsylvania.

Richard Kiy: Since 2001 Kiy has served as the President and CEO of the International Community Foundation (ICF), a public charity committed to promoting expanded cross-border charitable giving and volunteerism with an emphasis on the U.S.-Mexico border and Baja California. Prior to joining ICF, Kiy served as Senior Vice President for Business Development at PriceSmart, Inc., a leading emerging markets retailer with operations throughout Central America, the Caribbean and the Philippines. He was also a Vice President at Science Applications International Corporation (SAIC) where he served in both Mexico and Venezuela in the area of business development and environmental technology solutions.

Kiy's public sector experience includes having served as Principal Deputy Assistant Secretary for Environmental Health & Safety at the U.S. Department of Energy and over the years has held several other senior level positions in the U.S. Government including Acting Environmental Attaché at the U.S. Embassy-Mexico and Special Assistant for U.S.-Mexico Border Affairs at the U.S. Environmental Protection Agency. A graduate of Stanford University and Harvard University's John F. Kennedy School of Government, Kiy is also the co-author of the book, Environmental Management Along North America's Borders and is the co-editor of The Ties that Bind Us: Mexican Migrants in San Diego County.

Preface

Public health risks in the San Diego-Baja California binational region demand urgent attention. As the region becomes ever more integrated through cross-border economic partnership, commercial exchange, travel, and two-way migration, public health programs that work on only one side of the border are increasingly unable to prevent or respond to rising rates of infectious diseases, such as tuberculosis and HIV, chronic ailments, such as obesity, and, most urgently, the risks of bioterrorism, food contamination and other sources of transnational illness and threat.

Numerous studies continue to document the problems facing the binational region, but the dilemma is only partly a question of awareness. Rather, the challenge rests squarely with an institutional and political leadership stalemate that prevents turning knowledge into effective action. Existing health programs are small and fragmented, no coherent, integrated strategy exists to attract sufficient resources to make a difference, and the public sector on both sides of the border appears in no position to lead the way forward.

This Report highlights existing cross-border health deficits in the San Diego-Baja California border region, particularly in the areas of health care access and disease risks and identifies existing institutional barriers that are currently inhibiting expanded cross-border health coverage today. The report identifies that the need for expanded cross-border health services is now more urgent than ever before and this need now goes beyond existing border area residents to the growing number of fixed income Americans now retiring in Baja California due to economic reasons.

In an effort to offer practical solutions to overcome existing barriers this report offers a strategic agenda for improving the quality of cross-border health. Beyond the well acknowledged need to expand cross-border health research and to promote regulatory reform, the agenda includes the following specific recommendations; improve the leveraging of technology, particularly in the area of telemedicine; expand emergency cross-border health services; formalize cross-border anti-human trafficking protection teams; re-design disease-specific programs in the border area; and move beyond crisis to prevention as a strategy to expand the level of financing of cross-border health services.

The report also issues a call for action, beginning with a Regional Health Summit led by private and non-governmental leaders. The summit's objective would be to initiate a community-wide campaign to identify coordinated strategies to raise the scale

of investment and program engagement in cross-border health risks. These strategies would address the key binational question: What can be achieved working across the border that can not be achieved working separately on each side?

With this call to action, the International Community Foundation is inviting regional leaders to participate in the initial discussions that will lead to a Health Summit. This Report is designed to start that process. It provides background discussion on the nature of the problems that a binational health campaign must overcome and offers a few strategic ideas in hopes of stimulating discussion. Specifically, binational strategies need to design programs that closely match the ways in which people, communities, and the economy work across borders. To do so will require leadership that reaches across borders, overcoming an institutional mismatch between the way health programs are currently organized and paid for, and the ways in which individuals, families, workers and companies move, live and work on both sides of the border.

This Report is part of a series through which ICF is addressing the profound implications of cross-border integration in the San Diego-Baja California binational region. In its first report, *Blurred Borders*, ICF documented a range of policy issues that called for new perspectives and strategies requiring action from the private and non-governmental sector, philanthropy, and governments. Health security was one of the most urgent of those issues because of both the urgent risks facing the region and the potential capabilities this binational community could organize to address the problems.

The San Diego-Baja California region has both the reputation and experience with innovation to dramatically improve the health security of the economy and community on both sides of the border. A successful health campaign would also offer strategies of hope for other border regions that face similar problems but without the resources and inventiveness. As recent federal strategies for preparedness against pandemic influenza have admitted, health security risks can not be stopped at borders. Preparedness requires working across borders. In our binational region, community well-being, economic prosperity, and personal health all demand reaching across current boundaries.



PART 1

Photo Credit: ICF

INTRODUCTION

Shared destiny. A binational agenda for health in the San Diego-Baja California border region.

The National Strategy for Pandemic Influenza, released this May, confirms an understanding of health and borders long appreciated, but too often ignored, in the San Diego-Baja California binational region. Controlling borders only slows the spread of health problems, it does not prevent them¹. Effective strategies and actions require participation of governments, communities, and programs working comprehensively together across borders.

Of course, the San Diego-Baja binational region needs no alarm over the possibilities of pandemic influenza to appreciate the challenge of cross-border health risks. The Region's realities are sufficient. Yet, it faces a political and strategic stalemate in development of cross-border efforts to prevent and respond to ever mounting health risks. From accelerating rates of infectious disease transmission to fears of bioterrorism, continued failure to act together across borders threatens to ravage the well-

being of the binational San Diego-Baja economy and community.

Sounding the alarm and calling on leaders to participate in a binational strategy may appear too difficult in the present political and economic context. Perhaps those who warned New Orleans about category 5 hurricanes for two decades before Katrina understand the frustration. Today, the impact on the economy of ignoring health risks is already profound: Rising health care costs for small and large businesses, lower worker productivity, and burgeoning fiscal burdens on strained public coffers. Under the gleam of an otherwise prosperous region, disease risks are also widening beyond traditional at-risk groups, crossing the artificial barriers of social divisions and residential separation. Tomorrow, the acceleration of risks will have an even greater impact.

The economies of the border region are simply too inter-dependent, too intertwined to have an issue such as infectious disease cast under the rug because it is perceived to be too difficult or too large a problem for effective action.

¹ The National Strategy for Pandemic Influenza Implementation Plan. Homeland Security Council, May 2006, page 6.

With a need so clear and even urgent, why is there so little concerted effort among the region's leaders? The answer is not that the problems remain hidden. Numerous studies document a disturbingly wide array of health risks and challenges. The U.S.-Mexico Border Health Commission's Healthy Border 2010 Program, for example, describes twenty or so health problems that represent preventable threats to border health and well-being². The region's lack of institutional capacity in healthcare programs is also well-documented. The Border Counties Coalition recently concluded that, if the border region as a whole was considered a 51st state, it would possess the lowest level of health and wellbeing in the United States³.

The missing ingredient in this collective understanding of binational health risks is the persistent failure of political and institutional leadership to move from knowledge to action. Broad political and fiscal problems in the cities and counties on both sides of the border may be easily blamed. Institutional impediments on either side of the border also preclude concrete steps to address priority needs, especially when resources must be committed on the other side of the international line. So a stalemate persists.

Yet, perhaps the most evident barrier to action is a self-reinforcing one. Health programs and services suffer from fragmentation of effort into discrete, small activities that focus exclusively on one disease, treatment, or subgroup. Fragmentation reproduces limited capacity, even when a program is successful within its own objectives. Facing what appears to be a wide array of intractable problems and insurmountable need, financial supporters turn to favorites – the targeted disease that is politically visible at the time, a particular institution that does good work, a group that has effectively mobilized, or a medical approach that fits with the interests of the supporting agency or group. While each effort in itself is laudable, the result is a stalemate of too many investment choices, missed opportunities to obtain advantages from a comprehensive effort, and lack of a vision of public and private leadership that could bring significantly greater health resources to the binational region.

Fragmentation of programs and institutions also make it much more difficult to mobilize and sustain policy leadership in the large health risks and healthcare challenges in the region. Small, relatively weak border health programs and institutions make it much more difficult to “go to scale,” generating sufficient support and financial resources to reach a level of operation that could begin to im-

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prove health conditions at a community-wide level rather than only for a small number of individuals.

Delay in challenging and overcoming the political and economic stalemate on a comprehensive health care agenda for the binational region is no longer reasonable. Reliance on programs as they exist is also no longer acceptable. The answer is not necessarily to find new money to expand existing programs, nor is to wait for federal action on health care from Washington, D.C., or Mexico City. The need to promote local planning and action is essential. Throughout the region, health care providers and community leaders understand and recognize that concerted and collective action is needed in support of a broad-based, bold policy agenda, requiring innovation and strong political leadership on both sides of the border. They recognize that the public sector, in addition to playing a critical role in supporting the agenda, will need the private sector and the philanthropic sector to play a leading role because they have the capacity to work across the border, forming and supporting programs and initiatives that actually stretch across the borders to work with communities and institutions that also work across borders.

² US Mexico Border Health Commission.

³ U.S.-Mexico Border Counties Coalition, 2006.



Border Health Week sponsored community based health screenings.
Photo Credit: Liliana Osario, San Diego County Regional Coordinator, California-Mexico Health Initiative.

The binational region urgently needs a Cross-border Health Summit. The Summit should give voice to the urgency of the call for leadership on health issues to move beyond documentation of problems and near heroic annual struggles to keep benefactors willing to support specific programs. The call for leadership in a region renowned for its entrepreneurship and innovation should focus on the private sector, including business, philanthropy, and community-based as well as service organizations (Rotary, Lions, Shriners, etc). They need to join the public health sector and contribute their skills and capacities to shape a comprehensive, integrated approach. Private businesses and philanthropies have systemic opportunities and obligations within this area, not just to run parallel to government efforts but to carve out new mechanisms of system delivery that governments are ill-equipped to even attempt. Community-based organizations need to help design comprehensive approaches to health-care delivery that transcends their own initiatives that remain disease and subgroup-specific.

Public sector leadership should help this innovative campaign to expand the scale of health innovations, striving to reach a level of self-sustaining impact on the entire region. Public leadership, however, will have to overcome its own limitations. Strategies to prevent and mitigate health risks in a cross-border region must overcome a systemic problem – a fundamental institutional mismatch between the way in which people live their lives (in communities that cross the borders) and the jurisdiction, authority and financial support for most health programs that rests with separate government entities. In a binational region where no single place – a city, county, municipality or country -- encompasses the normal routine of the people who live in local communities, the primary challenge to building an effective public health system and generating political support is to generate innovative organizational approaches. Too much reliance on federal governments in Washington, D.C. and Mexico City or state authorities in Sacramento and

Mexicali only reinforces the leadership stalemate, in effect vetoing innovations that could stretch across borders to reach communities that share a common destiny.

The time is right, the risk is urgent. Throughout the region, healthcare is in such disarray, and health conditions so dismal for so many, that even a willingness to spend more money on health would be counterproductive unless the cross-border community engages in an examination of common priorities and strategies. A successful summit would call upon the region's health, financial, and political leaders to identify the binational region's health priorities, not just a list of needs. It would search for and find innovative solutions to problems arising from the institutional mismatch of cross-border authorities. And, it would lay out a roadmap to scale-up the array of energetic, small projects into a coordinated campaign that pushes the binational community to dramatically reduce its health risks on both sides of the border. Of course, cross-border collaboration will be a key to the success of such an endeavor.

This Report is a call to action and an invitation. It lays out the groundwork to begin a binational region-wide dialogue on a comprehensive health strategy. It also invites leaders throughout the region to step forward, to identify partners, to initiate action.

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PART II

CROSS-BORDER HEALTHCARE DEFICITS

One might excuse an outsider's surprise to learn how familiar and extensive the health problems along the U.S.-Mexico border are.

For years, health professionals and policymakers along the border have known, for example, that the U.S.-Mexico border has some of the most severe health conditions in the entire United States and the weakest health infrastructure to respond to them. For someone familiar with the region, however, it's hard to find an excuse for failing to respond to these urgent threats.

In March, 2006, the International Community Foundation (ICF) convened a group of binational public health practitioners from the San Diego-Baja California to participate in a forum in order to discuss the health priorities in the region and to begin to identify ways in which working together across the border could help. (See Appendix B for a list of forum participants). The forum participants, who represented several of the most successful regional health initiatives, discussed the border's more pressing needs and began to lay out strategies that have either worked on a small scale or that would be

needed to significantly improve cross-border health conditions. Clearly evident from the discussion was a solid understanding of the border region's health landscape. Equally clear, however, was uncertainty and hesitancy in how to engage a regional process that would both significantly increase investment in public health and health programs in the area and bring the cross-border communities together to build a strategy for identifying priorities and mobilizing necessary political and popular support.

The U.S.-Mexico border has some of the most severe health conditions in the entire United States and the weakest health infrastructure to respond to them.

Disease Risks

These practitioners' experiences echoed the health problems that have been documented both in the San Diego-Baja California region and across the U.S.-Mexico border as a whole. The immediate realities for many of the programs in which these participants worked involve a sustained increase in the incidence of infectious diseases. The increase is occurring on both sides of the border and is fueled by the continuing movement back and forth of visitors, families, and workers. The forum's participants frequently cited the prevalence of tuberculosis (TB) as a clear example of the cross-border risks they face daily. The incidence of TB at the border among all counties is twice as high as elsewhere in the United States.⁴

The disease risk that generated special concern and interests among the participants from the San Diego-Baja California region, however, was the rate of HIV infection. Tijuana is a large metropolis whose population of approximately 1.5 million people, is being increased on a daily basis by the constant influx of migrants from all over Mexico as well as people being deported by the U.S. back to Mexico. It has been well documented that Mexican migrants, the vast majority of which are young men, engage in high risk behaviors at a much greater rate compared to non-migrants. Being away from home for extended periods, exposure to several sex partners, using sex workers, sharing needles or men having sex with men all increase with migration.⁵ Although the "official" rate of HIV infection along the border in Mexico is only slightly higher than the national rate (16.1 per 100,000 persons compared to 15.2 persons per 100,000), the rate is increasing at a much faster pace than previously estimated.⁶ Men and women aged 15 to 49 years who are infected with HIV may be as high as one in 125 persons, which would place⁷ Tijuana's HIV infection rate close to three times higher than Mexico's national average.⁸

The incidence of HIV/AIDS in San Diego County is also high. At the beginning of the decade, San Diego had the sixth highest incidence of AIDS among California counties. Although the incidence rate was well below the target set by the Center for Disease Control (CDC) for 2000 (39/100,000), its linkages with the higher incidence of AIDS in Baja California and its disproportionate impact on specific subgroups made it one of the prominent health issues along the border. In a 2002 study, for ex-

ample, researchers examined blood samples taken from 374 gay and bisexual Hispanic male participants (18-29 years old), 125 living in San Diego and 249 in Tijuana. The study found that 35% of the men from San Diego and 19% from Tijuana were infected with HIV and had never been tested before.⁹ HIV infection also has a special impact on women. Pregnant women can pass the virus on to their newborns. A 2004 study conducted by UCSD found that pregnant women receiving care at Tijuana's General Hospital, whose patients are mostly poor, had a 10 times higher rate of HIV infection (1.2%, or about 48 mothers a year) than among women receiving care from a UCSD medical group.¹⁰

The social sensitivities and potential stigma that too frequently are associated with individuals infected with HIV also made this an important topic among community-based healthcare practitioners. Latino-focused AIDS education programs and other prevention efforts have uncovered cultural factors that affect the spread of the disease. Talking about one's sexuality, for example, is taboo in the Latino community. As such, many of the educational materials may not be as culturally sensitive and linguistically appropriate for some sectors of the Spanish-speaking population, let alone meeting the needs of new immigrants from regions of the country that speak Mixtec other indigenous Mexican languages.¹¹ Clearly, language and cultural barriers exacerbate new HIV infections and AIDS cases, and further concentrates this fatal disease within neglected portions of border communities.

Beyond the risks of tuberculosis, HIV/AIDS, and other infectious diseases complicated by the back-and-forth movement across the border, health threats associated with non-infectious disease are also on the rise. Today, the San Diego-Baja California border region, and the state of California as a whole, is facing alarming rates of obesity, diabetes and mental illness that disproportionately harm Latino youth. The risk has dire consequences for the future of the regional economy.

The binational region's future depends, in large part, on maintaining a healthy, productive workforce. Whether the costs of illness are born directly by employers or shared generally among the public through increased taxes, the health of children and youth, and of new immigrants into the area, will have an impact on the success of current and future economic growth. Yet, ominous signs warn about the growing incidence of obesity and childhood

⁴ The TB incidence rate among residents of all border counties is 10.4 per 100,000 persons compared to 5.1 per 100,000 persons for the U.S.

⁵ HIV Prevention with Mexican Migrants, Organista, et al, *J Acquired Immune Defic Syndrome* (37- 11/1/2004)

⁶ undertaken by researchers at the University of California, San Diego (UCSD) School of Medicine

^{7,8} Ibid

⁹ University wide AIDS Research Program (April 2002)

¹⁰ Cheryl Clark, "High HIV infection rate found at Tijuana hospital," *San Diego Union Tribune* February 11, 2004. Those who knew they were HIV-positive were not included in the study.

¹¹ *Sacramento Bee* (O'Rourke 12/1/2001)

diabetes among Latino youth. In the state as a whole, 24% of adolescents ages 12 to 17 are overweight or at risk for being overweight. African American and Latino adolescents have higher rates than both whites and Asians.

As a leading factor in the development of diabetes, obesity can kill.¹² In Mexican border communities, diabetes is the third leading cause of death; on the U.S. side of the border, the prevalence of diabetes is even greater.¹³ As more first and second-generation immigrants from Mexico adapt their lifestyles and diets to the American way of life, diabetes has increased substantially. The longer an immigrant lives in a U.S. community, the more they encounter cheaper, low-quality food and poor eating habits.¹⁴ According to a recent study by the CDC, with time these immigrants are more likely to become obese and develop diabetes, high blood pressure and heart disease. The CDC study found that 22% of Mexican migrants that had been in the U.S. five years or more were obese, compared to 16.1% who had been in the United States less than 5 years. As migrants stay in this country longer, diabetes rates rise from 6.9% to 7.5% and heart disease increase from 3.5% to 7.5%.¹⁵ The high rates of diabetes and hypertension in Latinos are also associated with a 50% higher rate of dementia or undiagnosed Alzheimer's disease.¹⁶

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North County Health Service's Mobile Health Clinic assist Mexicant migrant farm workers and their families. Photo Credit: Liliana Osario, San Diego County Regional Coordinator, California-Mexico Health Initiative.

Access Deficit

The forum participants, however, did not place any specific disease on top of the priority list of health intervention needs. Reflecting similar perceptions documented by researchers all along the U.S.-Mexico border, these local professionals reported that regardless of disease, the inability to gain access to healthcare was the critical unmet need that affected the entire cross-border community, including residents, migrants, rich and poor. The counties along the U.S.-Mexico border, where residents are most vulnerable to HIV/AIDS, tuberculosis, hepatitis and other infectious and non-infectious diseases, also have very low levels of health insurance and far fewer healthcare practitioners than the rest of the United States.

In San Diego County, although information on access rates is difficult to pin down reliably, various estimates show that 27 percent of residents are uninsured, the third highest percentage of all the counties in California. In turn, the state has the highest uninsured rate in the nation.¹⁷ Across San Diego County, health coverage varies not only according to income, but also according to ethnicity and citizenship/immigration status. In San Diego County, only 73% of Hispanic children had health

¹² California Endowment, "Saving California's Youth from Diabetes and Obesity" Fact Sheet.

¹³ Healthy Border 2010: An Agenda for Improving Health on the U.S.-Mexico Border, October 2003 ,page 26.

¹⁴ UC Davis Information System, 2005

¹⁵ "Hispanics Immigrant Health Problems Cited", Associated Press, March 2, 2006.

¹⁶ Journal of American Geriatric Society (Haan Oct 2002).

¹⁷ San Diego County Medical Society, 2006

insurance, compared to 94% of African-American and 93.4% of white children.¹⁸

Lack of access to healthcare also disproportionately affects large subgroups of the region's workforce. In particular, a staggering 96% of migrant workers interviewed in Vista, California, reported that they had no health insurance. Only 2% said they used employer-provided health insurance. Nearly half of the respondents had not seen a doctor in two years or more.¹⁹ All of the respondents said they were from Mexico and 49% were undocumented.²⁰

Evidently, along with the region's fast changing demographic landscape, its health care needs are also rapidly evolving. In addition to the wealth and opportunities available throughout the region, both sides of the border also share in poverty and poor healthcare. Not surprisingly, the prevalence of infectious disease is greatest among the poor and least able to receive medical care. In Tijuana's fast growing colonias populares or shantytowns, many still lack basic public services, making them vulnerable to infectious and otherwise preventable water borne diseases. San Diego County faces similar challenges in many of its migrant communities. Migrants living in worker camps are especially threatened and vulnerable to infectious disease.²¹

The March forum participants also highlighted occupational injuries as an often neglected source of health problems in the region. According to Don Villarejo, a UC Davis researcher, "It's well documented that farm workers suffer high rates of fatal and nonfatal work-related injuries and illnesses, but 70 percent of laborers hired to work on perishable crops in California lack any form of medical insurance."²² Not surprisingly, the mix of low wages, no insurance, little access to health facilities, and physically hard work increases the occurrence of repeated injuries. The migrant workers in this region, spreading out from the fields of San Quintin in Baja California to Escondido in San Diego's North County, face a wide array of workplace hazards and occupational injuries ranging from physical injury, pesticide exposure and heat stress.

The cost of these uninsured rates and lack of access to healthcare may be hard to document with precision, especially through indirect impacts on productivity and other costs to employers. Undoubtedly, there is a significant human toll. The fi-



Mexican migrant workers in Carmel Valley, San Diego with Alejandra Ricardez, board member of the Oaxacan hometown association, COCIO (right). Photo Credit: ICF

nancial costs, however, result from the combination of lack of access to healthcare, lack of insurance, and low per-capita income. In one study, migrant workers' sprains and strains cost the agriculture industry an estimated \$1.266 billion in 2005 from lower productivity and lost hours of work.²³ This mix of circumstances also contributes to the high cost of uncompensated care about which hospitals in border areas complain. According to one estimate, the hospitals in the border counties on the U.S. side provide \$800 million dollars annually on uncompensated care.²⁴ It is not clear however what portion of this amount is due to care given to legal or undocumented immigrants without health insurance.

The healthcare access deficit in the binational region, however, is not limited to these familiar conditions and migrant workers. Cross-border health care access and availability is a growing concern for the emerging California baby-boom population that is now approaching retirement. With insufficient personal savings to maintain a desirable lifestyle in the state, many are increasingly looking to spend their golden years south of the border in Baja California. At least part of the attraction is the proximity to San Diego and the availability of U.S.-based health care just across the border. Their

¹⁸ San Diego County Child and Family Health and Well-Being Report Card 2002, p. 27.

¹⁹ Information in this paragraph was obtained from Dr. Bade's power point presentation on November 14, 2003, Center for U.S.-Mexico Studies, UCSD.

²⁰ According to the findings of Bonnie Bade, California Endowment study.

²¹ California Endowment, "Suffering in Silence", pp. 25-26.

²² "Policy Recommendations Made for Improved Health of Hired Farm Workers", Winter 2006, 2006-1,

²³ Anna, Carla, "New picking season brings ergonomics to the field," *San Diego Union Tribune*, April 3, 2006.

²⁴ U.S.-Mexico Border Counties Coalition, 2006.

Difficulties in crossing the border with long traffic delays and the higher costs of seeking care north of the border is also prompting a growing demand for healthcare services in Mexico.

resettlement is creating a new twist to providing access to healthcare across the border. Difficulties in crossing the border with long traffic delays and the higher costs of seeking care north of the border is also prompting a growing demand for health care services in Mexico.

For retirees who remain in San Diego and its surrounding counties, Baja California is increasingly a place to turn for more affordable dental care and prescription drugs. The extent of San Diego area residents now relying on medical care in Tijuana is not well documented. In Los Algodones, a small Mexican border town located across the border from eastern Imperial County thousands of people cross the border each year to receive primary care or homeopathic services, go to a dentist or an optometrist, or purchase prescription drugs from the more than 20 local area pharmacies.²⁵ Current FDA regulations allow U.S. citizens to purchase and re-import a three-month supply of prescription medications with a valid Mexican or U.S. prescription. Prices in discount drug stores in Tijuana can be as low as 40% or even lower than the price for the same medication in San Diego.

While the prescription drug market in Baja California is more cost-efficient than in San Diego, the quality of healthcare and specifically drugs is less certain. The industry is far less regulated in Mexico than on the U. S. side of the border and Americans purchasing services and medication have, in some

cases, been victims of fraudulent practices. By law, prescription drugs sold in Mexican pharmacies require a prescription from a licensed Mexican doctor. Yet some Tijuana pharmacies accept prescriptions from the U.S. and there are reported incidences where no such prescription is required. Though many residents on both sides of the San Diego/Tijuana border may benefit from affordable medications, without accredited medical consultation the practice can lead to serious medical consequences. While this is so, the existing policy leaves it in the hands of the consumers to exercise judgment and to follow the advice of their physician or pharmacist.

For the number of Mexican citizens living in San Diego without adequate health insurance, crossing the border back home is also increasingly a viable option to access healthcare. Similarly, a growing number of San Diego residents who have become border commuters, residing in Baja California but working in San Diego, medical insurance options now include plans that provide alternative, culturally competent medical care in Mexico as well as in San Diego. The Mexico-based options are often much more affordable than similar arrangements. Although slowly developing, cross-border plans such as Servicios Medicos Nacionales, S.A., Access Baja HMO (a product of Blue Shield of California), Salud con Health Net, and PacificCare now may offer new ways to organize healthcare access in a cross-border community. Mexico's Social Security system (Seguro Social) also sells an insurance product that covers the cost of health care provided in Mexico to a person working in the U.S. or their family members back home.

Not all borders in this binational region are international. A growing number of San Diego's workers now live in bedroom communities not only in Baja California but also Imperial and Riverside Counties. A sizable number of San Diego's North County residents also regularly commute north to Orange and Los Angeles Counties. These residential-work patterns are defining new boundaries of community and economy that also influence health needs and programs. Health issues and programs that respond to the entire binational region need to address this broader regional context requiring providers, employers, consumers and governments to look beyond traditional jurisdictional boundaries, regardless of whether the jurisdiction is a city, county, state, or national government.

²⁵California Connected (KPBS May 22, 2003)

Pandemic Health Risks

In the midst of the national attention to pandemic influenza, the March Forum obviously recognized the new, but critical need to upgrade the public health infrastructure in the region. The San Diego-Baja California crossborder region, however, added special features to the national strategy. Within its boundaries, the region has the busiest land port-of-entry in the world, two international airports, both commercial and military seaports, and a crossborder rail transportation system. On both sides of the border, this infrastructure is critical to the security of the region and its economic well-being. Pandemic flu, which could cause nearly 40 percent of a region's workforce to remain at home and kill hundreds of thousands, represents perhaps the most plausible, catastrophic cross-border risk.

San Diego-Baja California is particularly vulnerable to the spread of avian flu because of the region's high degree of urbanization and the large number of its people living in urban slums. According to Tijuana's planning agency, IMPLAN, about 30-40% of residential areas in that City remains squatter housing without electricity, potable water, and sewage.²⁶ Such dreadful living conditions are not just limited to Tijuana. San Diego County's high cost of housing forces many migrant families to double and triple up, often with 10 to 12 people living

in the same apartment. Perhaps as many as 10,000 migrant workers live in migrant worker camps in San Diego County without adequate electricity, sewers, or running water.²⁷

These sub-standard living conditions are potential bird flu incubators because humans and chickens live in close proximity. Mexican communities on both sides of the border are particularly vulnerable because many families raise chicken for domestic consumption. Other households own caged birds and roosters for cock fights. While widely considered an illegal activity, los Palenques or cockfights are quite commonplace. In the United States, the outbreak of the exotic Newcastle disease in 2002 among poultry in California, Arizona, Nevada and Texas was attributable, according to the US Department of Agriculture, in large part to illegal cockfights. The disease cost taxpayers about \$200 million to contain. It cost the poultry industry many millions more in lost export markets.²⁸ And, the fights can be deadly to humans. In Asia, at least four children died last year due to exposure to bird flu from cockfighting activity, according to news reports.²⁹

The recently released implementation plans for the **National Strategy on Pandemic Influenza** call for addressing the threat of a flu pandemic through greater cross-national cooperation. In the



Informal housing, Cañon Los Laureles, Tijuana. Photo Credit: ICF.



Mexican migrant workers at Camp Del Mar near the community of Carmel Valley in San Diego. Photo Credit: ICF

²⁶ The City of Tijuana and the State of Baja California are working proactively to prevent the creation of colonias populares and have successfully stopped 14 land invasions in 2001-2002. They are also working to relocate up to 1,000 people that are currently in communities that are in high risk zones that are vulnerable to flooding and landslides. Source: Sandra Dibblezh, "Evictions on Tijuana hill turn messy-Outcry follows; critics question city's motives," *San Diego Union Tribune*, August 21, 2002, B1

²⁷ Research by Professor Bonnie Bade, California State San Marcos

²⁸ *The Game Fowl News*, 2/18/2006

²⁹ *Ibid*

San Diego-Baja California region, cooperation is a necessity, not just desirable. Yet, homeland security strategies related to pandemic flu and other cross-border risks rely on measures that, by the Federal government's own admission, will have only partially successful effects. Travel restrictions, quarantines and even closures of ports-of-entry are familiar containment measures, but especially in the San Diego-Baja California area, their effectiveness will be minimal. As the immediate aftermath of the 9/11/01 attacks showed, the pressures to open the border to trade and travel as soon as possible after the tragedy were overwhelming.

Federal plans also call for more careful and extensive screening for infectious diseases and contaminated goods at the borders. While undoubtedly a useful health measure, reliance on steps taken at the border is only a partial solution. Joint San Diego-Baja California efforts are needed to prevent disease throughout the entire region and to take immediate, effective mitigation action. Although there has been some discussion and plans to share the U.S. national stockpile of vaccines across the border in case of an outbreak, the measures are not well known and, in the absence of education, are opposed by the general public.³⁰

Preparation for pandemic influenza and other lethal infectious diseases, however, offers the bina-

tional region an opportunity to greatly expand its infrastructure and strategic thinking on cross-border health solutions to everyday communicable conditions. For too long, health advocates and officials from both Mexico and U.S. have been caught in a dilemma. They clearly needed to address health concerns for their residents, and disseminate information about the sources of potential health hazards and risks that threaten people everyday such as TB and HIV/AIDS, as well as the rarer epidemics. Yet, without a fully collaborative foundation that engages both sides of the border, that information often relies on pointing across the border as the source of various problems. In the past, for instance, Mexican health officials warned their citizens of the potential impact of bio-terrorism and the spread of SARS and West Nile Virus emanating from the U.S. side of the border.³¹ Similarly, an outbreak of hepatitis A in the United States led U.S. health officials to point to its source among harvested green onions from Baja California.³² The USMBHC has been quite successful in achieving one of its goals that is pertinent here, binational cooperation, trust and an openness when dealing with any cross-border health problem, potential or current. Still, a binational approach to pandemic influenza preparedness could enhance the motivation and urgency to break the stalemate in the region that prevents broader bilateral action on all health matters.



The recently released implementation plans for the National Strategy on Pandemic Influenza call for addressing the threat of a flu pandemic through greater cross-national cooperation.

³⁰ Institute of Medicine

³¹ See, for example, Frontera Norte Sur (online publication), June 18, 2003.

³² See, for example, Diane Lindquist and Sandra Dibble, "Clues, but no smoking guns," *San Diego Union Tribune*, December 15, 2003.



PART III

INSTITUTIONAL BARRIERS TO CROSS-BORDER HEALTH

If the binational healthcare practitioners that ICF convened in March held one common view, it was how difficult the task was to work effectively across the border.

All worked directly with local border communities and repeatedly honed in on how routine community activities involved extensive cross-border connections and movement back and forth. They also noted how these cross-border realities had profound implications for health determinants, disease transmission, and access to public health services. People exposed to poor health conditions or disease in Mexico, for example, easily transmitted them into California through cross-border travel. The risks were also reciprocal: recurrent movement back and forth across borders reinforced conditions throughout the transborder community. For instance, poor health conditions, disease, and risky behavior learned among community members living in the United States affected their spouses and children

living in Mexico. Many of those children will someday migrate to the United States.

The challenge faced from this experience by healthcare professionals is how to organize and sustain healthcare programs and services that adequately and appropriately match the ways in which their clients lived in this cross-border reality and how to shape their services to truly reach the various facets of their community members' lives. Part of the problem, they reported, involved the difficulties encountered working with Mexican agencies and colleagues who work under a different health and political system.

The obstacles were institutional, not interpersonal or cultural. Echoing observations of participants in a National Latino Research Center (NLRC) border health 2004 study,³³ ICF Forum participants reported that their partnerships involving Mexican agencies and colleagues had been limited because of inadequate funding on that side of the border and restrictions from U.S. funders that do not allow expenditures in Mexico. This creates a core ine-

³³ National Latino Research Center, "Best practices in Border Health and Bi-National Collaboration". Border Health Research Report, October 2004.

quality within the binational partnerships. Mexican colleagues often feel neglected and taken advantage of, which further contributes to failed collaboration.

These problems, however, were only part of an overall dismal scene. NLRC researchers, for example, identified four categories of impediments to border health programs. Border health programs were characterized as having isolated and uncoordinated efforts, a weak organizational infrastructure, an absence of models or best practices to attract additional funding, and problems of sustainability. Sustainability was perhaps the most important source of problems. Donors often sought to support new programs with short-term results, leaving established programs providing routine services to struggle for annual support.

As difficult as these barriers are, however, the problems go far deeper than the need to provide more funding for existing programs. Programs are in general short supply, and where they do exist the efforts are fragmented among a relatively long list of priorities. For instance, across the entire U.S.-Mexico border, over 80 percent of border counties have primary care Health Professions Shortage

Areas (HPSAs). Ratios of primary care physician to local populations are 25 percent lower in border counties than among average counties in the United States.³⁴

These border healthcare problems reflect fundamental dimensions of the political and economic structure of border communities. They are difficult to overcome. Yet, to successfully meet the considerable health needs of the border, each must be fully addressed.

First, programs and services committed to community health must restructure to match the way families and individuals in the region organize their lives. Cross-border health policies and programs, however, have been generally unable to overcome this organizational challenge. In particular, they have not fully responded to the significance and uniqueness of what “community” means in the border region. Community, of course, is the cornerstone of public health. According to the U.S. Department of Health and Human Services (DHHS), health professionals have reached consensus on the close link between an individual’s well-being and the health of the community and environment



Children at Tijuana General Hospital, Photo Credit: Amy Carstensen, ICF

³⁴ Health Workforce Needs: Opportunities for U.S.-Mexico Collaboration. Conference Proceedings and Background Papers, Center for Health and Social Policy, Lyndon B. Johnson School of Public Affairs, The University of Texas at Austin, and the Regional Center for Health Workforce Studies, Center for Health Economics and Policy, The University of Texas Health Science Center at San Antonio, November 2003, <http://www.utexas.edu/lbj/faculty/warner/prp0203/papers.pdf>

³⁵ Department of Health and Human Services, 2005.

in which they live, work, and play.³⁵ The World Health Organization (WHO) embraces a similar approach, focusing its initiatives on the “causes behind the causes” of illness – the social determinants of health which, according to DHHS, are profoundly affected by the “collective beliefs, attitudes, and behaviors of everyone who lives in the community.”

In a binational region, where are these collective beliefs and attitudes, the environment of work and play, if not on both sides of the border and in the behavior of crossing back and forth? The “community” that forms the foundation for successful health care stretches across neighboring borders to link family and community members living in different locations. A healthy border community, therefore, is one in which the health of any single individual member, on either side of the border, is determined by the health of communities on both sides of the border. Improving the health and reducing the health inequities throughout this region is the challenge and responsibility of all who work within the binational region.

Facing the realities of cross-border communities may be the greatest initial challenge to border health, and one that has escaped decades of work on each side of the international line. The “continuum of care,” which is the strategic target of health programs, involves new dimensions when it intersects with the dispersed geographical patterns of border communities. This continuum involves the core interconnections of different stages of an individual’s life cycle, including the sequence of exposures to various diseases, preventive behaviors, and risks encountered throughout that person’s life and range of activities. A recent World Health Organization study demonstrates the central importance of these interconnections:

“[c]oordination along the continuum of care between safe motherhood and child survival programmes is essential if substantial advances in neonatal survival are to be made. Many other types of vertical programmes also affect neonatal outcomes, including family planning, immunisation, sexually transmitted diseases, and HIV/AIDS. Child health programs are working to strengthen clinical care, integrate outreach services, and step up behaviour-change approaches.”³⁶

In a border region, the strategic lesson is simple: an effective approach to health care at any particular time or place is thoroughly dependent on what has happened before and on the other side of the border.

Strategically, a new approach to healthcare in the region must design health services, finances, and organization to match the way families, communities, and professionals work along this continuum of care. Yet, this approach would require attention to the sequence of geographical moves and the environments which individuals encounter at different locations. That is, the “continuum of care” in a cross-border community includes a geographical dispersion of many of an individual’s interconnected phases of treatment or root causes of poor health that may be manifested in any stage of life. As a result, the approach requires program linkages between places of origin, their community of upbringing, the risks at the workplace, and the community in which the residents live while abroad.

In a border region, the strategic lesson is simple: an effective approach to health care at any particular time or place is completely dependent on what has happened before in that particular locale and on the other side of the border. Health programs that are designed to prevent or treat illness that address only one location are doomed to failure. Program organization needs to match the interconnections that exist in community members’ lives and provide a capability to intervene at all points in that web of influences. Programs designed or limited to working on only one side of the border are unable to make headway against a set of disease risks, unhealthy behaviors, and environmental conditions that stretch beyond their reach. The staff that works on these programs needs to be equally comfortable

³⁶ World Health Organization, “Scaling-up health care delivery from pilot innovations to policies and programmes,” 2006, page 4.

working on either side of the border or at least be willing to take the time to visit and understand the environment that their target population faces on a daily basis.

Scaling Up

A second challenge facing the private, non-governmental and public healthcare sectors along the border is how to increase the scale of operations and impacts. Even successful, small scale, targeted programs become self-defeating when they reproduce competitive, unorganized efforts to attack disjointed aspects of border problems. Border health care is not alone in needing to face up to this problem. Scaling up, as the challenge is referred to around the world, is a persistent challenge to healthcare systems everywhere.

Scaling up goes well beyond what is typically meant by capacity building along the border. Successful capacity-building efforts also need to reach a higher scale of operation that requires transformation of programs and redefines targets, tactics, and treatments. A recent report from the WHO shows that enlarging the scope and scale of health programs, and becoming more effective for more people, requires much more than additional funding and marginally more staff or capacity. It involves “practical, organizational transformations” and new strategic choices around health service innovations.³⁷

Scaling-up is an institution-building process, however, that does not necessarily fit well with philanthropic and public sector supporters of border health programs. The process takes time, which does not coincide with the interests of donor agencies and policymakers bent on seeing immediate results. The institution-building strategy may also be at odds with a “project-oriented” funding approach, where specific investments are expected in two or three years to deliver a narrow range of results.

Lack of a comprehensive strategy for scaling up virtually ensures failure to make progress against increasing disease risks. It reproduces the fragmentation and weakness of current infrastructure and reinforces perceptions that additional funding will have little impact on health outcomes. Lessons learned from scaling up efforts around the world show that a critical component of a new strategy

requires formation of a resource team to help organize a more comprehensive program and help play a strategic and ongoing catalytic role. These teams help governments and philanthropic organizations find ways to bring change to those programs that are already showing progress, but at a smaller scale. The team provides a collective approach to advocacy, research, and technical assistance that can make greater headway in attracting public sector support than having managers and directors campaign for their own programs.

No such resource or leadership team that focuses on the overall value and performance of binational health care currently exists in the San Diego-Baja California region. The ICF Forum participants agreed that government agencies do not provide an umbrella leadership structure for their programs, although the USMBHC is developing this role. Given the range of public sector problems on both sides, Forum members also thought one such organization would be insufficient for this task. The group acknowledged that the key missing element in the binational region’s leadership on health was the private sector. Private business, working as strategic partners, with philanthropy and community-based organizations and USMBHC had a much greater opportunity than governments to identify innovative and coordinated approaches to cross-border health challenges. The business sector recognizes the potential benefits in developing cross-border projects in areas such as clinical trials for pharmaceuticals. Mexican communities would also benefit from increased foreign investment by improving the health infrastructure, enhancing the capacity of health professionals and increasing access of the population to new therapies.³⁸ Philanthropic organizations have the flexibility to play a key niche role in providing support to the resource teams and pilot tests, while private entrepreneurs had the expertise to organize activities at a scale that might actually meet the actual size of the risk and opportunity. The USMBHC could house the umbrella function of all working together.

Institutional Mismatch

A third barrier to effective cross-border health is systemic and, as such, much more difficult to overcome than even the two challenges discussed above – designing to meet the geographically dispersed continuum of care and the need to increase

³⁷ Ibid

³⁸ Borderless Innovations, San Diego Dialogue, 2006

scale. The third barrier involves an “institutional mismatch” that undermines the ability to work across borders. In short, health care entitlements are national in nature, the responsibility of each government to take care of the “general welfare” of its own people. Yet, in a border community where people and families live on both sides of the border, and their health is clearly linked to environments and activities on each side, this national responsibility is misaligned with what people need and the way they organize their own lives. Institutional authorities that define eligibility for service and decide on the availability of resources are rooted in government jurisdictions which do not have the capability or even obligation to respond and serve cross-border community members. Treating the border region as a whole is imperative to serving these communities.

This institutional mismatch between jurisdictions and communities, quite simply, is a form of structural disenfranchisement and disempowerment. Which government represents a community that has part of its members inside one State and part in another? To which institution does a community as a whole turn or petition for help if the institution itself does not cross the border and have authority to work on both sides. In this binational region, the two governments have radically different approaches to public health. Under the Mexican Constitution, public health is a federal responsibility and the primary policy decisions are made by officials in Mexico City, in some cases in the state capital, but seldom at the local level. In the United States, public health is a state responsibility, often with authority for decision-making resting legally with county officials. The result is fragmentation of authority and responsibility, overly complex and complicated organizational structures, and non-responsive public authorities. Local communities, officials, and business people are stymied by distant or disjointed capabilities and perspectives. While this is so, it is worth noting that the USMBC was created, in part, to bring both countries together at least among governmental agencies: local, state and federal.

Participants in both the 2004 NLRC study and the 2006 ICF Forum talked about the effects of this mismatch. At a community level there was no shortage of informal, interpersonal negotiations between Mexican and U.S. officials. Some of the most successful project fund-raisers were among the best ‘negotiators.’ However, as heroic as these creative efforts have been, they undermine a capacity to deliver adequate service and organize a strategy

for health care that could have a sustained impact in the region. What should be a formal structure of responsibility, even a right from an individual’s perspective, remains a persistently contested matter of separate negotiations.

Institutional mismatches are not as daunting a challenge, however, as they may first appear. Similar misalignments between jurisdictional authority and the ways in which communities organize themselves are fairly familiar in the United States where urban sprawl has pushed the realities of economic and social life beyond traditional city boundaries and responsibilities. Metropolitan economies and communities have replaced the sole authorities of city and county as people routinely travel back and forth to work, shop, visit, and live. Institutions of authority, including traditional community and neighborhood-based associations, no longer have power over all parts of the activities important to their citizens, residents, and members. Mayors can only partially influence the local economy, for instance, if many of those who work in the city live in the suburbs, are taxed under a county’s jurisdiction, and vote in totally separate elections. No one



Children’s Physical Exams at the Health Fair in San Ysidro Health Center
Photo Credit: Elizabeth Santillanez

government entity, no single organization, represents the interests, assets, and desires of the people who organize their lives on this regional as opposed to city scale.

Of course, when communities and economies “sprawl” across boundaries that represent national governments, the severity of the institutional mismatch becomes itself a defining feature of community organization. Members of the same community are separated from each other, disenfranchised from participating in activities that could otherwise serve the entire group, and unable to seek service from a single entity. No government, health care institution, or organization is accountable to these cross-border community members. One reason immigration policies and politics become central to discussions of health care is that the movement of community members confronts this fundamental mismatch – which government serves the person who is moving between locations throughout our binational region?

These mismatches, of course, are not unique to the U.S.-Mexico border. In Europe, where cross-border health issues have long been a target of European Community-wide integration efforts, this mismatch between institutional authority and social needs is discussed as a problem involving the ‘principle of territoriality.’ Despite successive revisions of the European Community Treaty in hopes of addressing the health problems of cross-border integration, health care delivery remains primarily a matter of national competence and responsibility. Funding schemes limited to social security, taxation or other nationally-based systems ensure that those jurisdictions must retain authority over eligibility, coverage, and quality.

The European Community, however, also struggles with ways to transform its health care system beyond this territoriality principle to find ways to more adequately and appropriately serve workers, families and professionals moving across its many borders. For example, governments have reached agreements to guarantee health coverage to migrant workers and their families. Although some problems related to these workers’ eligibility for services on both sides of the borders have arisen, the more prominent challenge remains how to educate and encourage access to health care for those whose health expenses are not covered on either side of

the international lines.³⁹

The European Community has also worked to improve the access for health professionals to contract and perform services across borders. On a much smaller scale, California and Mexico have tentatively wrestled with similar steps to facilitate healthcare in a cross-border community. Over the last few years, for example, the California legislature has debated legislation that would allow small numbers of Mexican doctors and dentists to practice in California for a limited number of years.⁴⁰ Such programs would provide much needed healthcare professionals to help serve the working poor, especially in rural areas. They would also help reduce state medical costs, delivering care more efficiently and less costly than in current programs and practices that often produce uncompensated care for services in emergency centers.⁴¹

Not surprising, the strongest source of controversy about these limited cross-border programs has come from public and private jurisdictions that represent people in different parts of the community. State of California officials, for instance, have worried about the standards of training and the fairness of the distribution of care. The private California Medical Associations have opposed rules of program participation and the practice of medicine that are different than those which govern California physicians. Also, it may be difficult to keep these professionals in the truly needy areas. The possibility of a permanent location in the United States tempts many and they often want to move to the more affluent areas to practice. On the Mexican side, health authorities have barely enough resources to provide basic health care to a huge number of people and complain that U.S. visitors in need of services while in Mexico have the expectation that they will be provided with comprehensive care equal to what they are used to in the U.S.

Still, as difficult as these innovative programs may be to organize, they represent promising approaches to the realities of health risks in a cross-border economy and community. They also stand in stark contrast to current government policies, many foundations’ rules and strategies, and even the practices of most community-development programs along the border. These existing approaches limit their work to only a fraction of the community dimensions that determine current and future health conditions, risks, and opportunities for improve-

³⁹ European Observatory on Health Systems and Policies, *Cross-Border Health Care in Europe*, page 6.

⁴⁰ One such effort, AB 1045, would allow 30 licensed physicians and dentists from Mexico to practice in California for 2 or 3 years.

⁴¹ CMA Balks as Calif. Eyes Mexico To Recruit Docs To Serve Latinos, *Managed Care*, November 2001.

ment. Ultimately, this limitation calls into question whether current strategic programming is simply designed to fail. Incomplete program designs compromise care, sever services, and diminish the capacity of community members to mobilize and help themselves. There is a kernel of a good solution in these guest programs but they need a lot more work and compromise to become a reality for the most needy.

Public policy approaches to cross-border health

A search for new strategic thinking on binational healthcare requires a full review of public policies and how they stack up to the challenges and needs of cross-border communities. Many current policies are counterproductive, helping only segments of the community in the name of empowering the entire community. Others are punitive in their efforts to block community-level, cross-border transactions and movements, or to separate out those who are eligible for care from those who are not.

Current policy approaches form four broadly-defined models of cross-border public health strategies.



Dental screenings at La Maestra Dental Clinic, San Diego.
Photo Credit: Elizabeth Santillañez

A. Governments Go It Alone: Block and Screen

Historically, governments routinely and unilaterally intervened to stop the movement of people across borders in an effort to reduce health risks. In earlier times when migration did not lead to such tightly integrated, cross-border communities as they do now, governments could intervene more easily, prevent movement back and forth and reduce disease risks through immigration controls. The near legendary practices at Ellis Island at the height of the transatlantic migrations provide clear examples.

The public health logic of such unilateral efforts remains strong. The SARS epidemic brought officials back to these earlier techniques. At airports and other ports-of-entry, travelers were asked if they had a dry cough, fever or nausea or contact with anyone with symptoms. At some airports, travelers received a modern version of the Ellis Island “six second medical” – a thermometer stuck in their ear or, unbeknownst to the traveler, an invisible scan by a hidden thermodetection device. Current planning for pandemic influenza takes a similar path. Expanded quarantine stations, restrictive border closures, and enhanced capabilities to screen travelers are all part of recently published plans.

Another motivation behind this approach involves the rising costs of border medical care. The debates and political outcries about the costs of health care services for immigrants and their impact on health infrastructure continue daily. Many hospital officials and lawmakers say that the cost of providing uncompensated care to people from Mexico places additional stress on facilities that already face overwhelmed hospital staffs and a growing patient population. Los Angeles Supervisor Mike Antonovich once proclaimed, in reaction to the large number of immigrant patients, “Los Angeles County cannot be the HMO to the world.”⁴²

One proposed solution is to physically block transnational community members from crossing borders. Another, similar strategy attempts to deny care to certain groups. In California and elsewhere along the U.S.-Mexico border, governments have moved to define which members of communities and families may have access to health facilities and

⁴² “LA Emergency Rooms Full of Illegal Immigrants,” Fox News, March 18, 2005

which can not. Even though employers in the U.S. benefit greatly from low-wage immigrant workers from Mexico, there seems to be no sense of responsibility to provide their workers with basic health coverage nor does the U.S. government feel the need to compel the employers to provide such services. As necessary or valuable as these and related approaches are, the goal is primarily to suppress the cross-border activities that are so deeply rooted in the global economy and society, rather than focusing on the health risks themselves. Policies work against the community, not with it. In a sense, the approach puts its primary emphasis on physical and social dimensions of quarantine and screening. Yet, even in emergency situations, efforts at confining the problem have proven less than adequate and often counterproductive.

B. Government-to-Government Coordination

The limits to governments working alone to combat transnational disease risks, of course, have been acknowledged for decades. Mexico and the United States began cooperating as early as 1927, when they responded together to emergency health conditions caused by floods along the border. Formal U.S.-Mexico cooperation began in the late 1940's when health authorities realized that separate and isolated efforts on each side of the border to control syphilis and gonorrhea were unsuccessful because they involved shared infections among community members living along the border and crossing in both directions. In 1942, the U.S. Public Health Service asked the forerunner of the Pan American Health Organization (PAHO) to help coordinate a border health campaign. The meetings spawned the U.S.-Mexico Border Health Association (USMBHA), an organization of health professionals from both sides of the border that has met annually since 1943.

Although professional development and communication represent a valuable enterprise, government-to-government program coordination has unfortunately been limited to annual calls for more cooperation and not much concrete progress. For instance, when U.S. and Mexican health officials met for their annual meeting in 2002, no one was apparently embarrassed to declare, after sixty years of coordination, that this year's event was a "dramatic first step" toward improving binational cooperation for better border health. The Texas

Commissioner of Health at the time said, "We must build strong relationships, improve communications and work together if we are ever going to seriously improve the health of citizens on both sides of our border." The Consul General of the Mexican Consulate in Austin repeated the familiar refrain, "As we all know, disease knows no borders. Cooperative efforts involving all sectors of society are key to outsmarting this disease"⁴³ (tuberculosis).

These government-to-government programs have generated far more hope and expectation than they have delivered on-the-ground assistance. As the U.S.-Mexico Border Counties Coalition has recently documented, border communities are even less prepared today to handle rising trans-border disease risks than before. More and more people cross the border, communities become even more integrated and interconnected, and yet the prospects for an integrated public response remain stymied.

Part of the reason is that these inter-governmental, Mexico-U.S. health programs fail to overcome the institutional mismatch represented by the border. Their annual efforts actually reinforce it. The proposed government programs remain separate and unequal efforts, each pursuing parallel goals on separate sides of the border, hoping that their independent pursuits will reach parallel outcomes. They fail, however, to identify and work with the dimensions of communities that cross the border and sustain connections that share disease risks, stimulate unhealthy behavior, and divide opportunities for health care between different family and household members. Here again the USMBHC has made some progress in bringing the public health professionals together for research, education and treatment of various common illnesses, such as tuberculosis.

C. Civil Society Engagement

Although governments are usually the most powerful health sector actors, their resources and authority to influence community activities weaken in cross-border affairs. In nearly all inter-governmental programs, their comparative advantage relies on internal reforms. For instance, in the fight against tuberculosis, the Mexican Ministry of Health has its most leverage in combating the disease within its own rural communities and through substantial reform of its own health care delivery systems.

⁴³ "U.S.-Mexican Health Officials Hold Austin Symposium for Joint Tuberculosis Campaign", Texas Department of Health, Office of Border Health, February 7, 1996

The capacities of civil society to augment and influence health conditions and health care beyond government actions are, of course, topics of widespread, global discussion. In the context of U.S.-Mexico relations, however, attention to the contributions of civil society organizations to improving health is relatively new. To some extent, this is not surprising. Civil society organizations in Mexico are on the whole in the early stages of development. While there are effective health-related practices in Mexico, these have not generated an extensive network of providers and community-level organizations with any substantial capacity to advocate within the highly centralized, Mexican federal government for health resources and attention. One notable exception is the Mexican Red Cross. Not only has this organization taken on the role of being the primary provider of ambulance services throughout Mexico, it has recently become involved in providing health care and education to

In the last few years, the Mexican government has reached out to civil society organizations to forge a public-private partnership aimed at improving health access to the Mexican migrant community in the United States.

U.S. bound migrants in order to reduce the deaths of undocumented people attempting to cross the border illegally. Notwithstanding this exception, lack of civil society participation in Mexico remains a critical source of the institutional weakness along the border.

In 2002, dozens of foundations formed the Border Philanthropy Partnership (BPP) to foster civil society capacity along the U.S.-Mexico border. Over the last four years, BPP has done much to catalyze expanded community-based philanthropy with an emphasis on addressing critical border issues including concerns over border health. For the most part, however, its focus underscores rather

than overcomes the limits of most border initiatives. The emphasis is largely limited to activities that take place on either side rather than involving a conscious effort to organize in a cross-border fashion. At most, these and other civil society initiatives attempt to coordinate parallel actions among small associations and groups separated by the border. Cross-border relationships remain issue-specific campaigns or information sharing activities. Unfortunately, the result is typically to produce weak coalitions of interests rather than an integrated cross-border initiative. Border groups' futures remain very uncertain as they face tremendous difficulties just in maintaining day-to-day contacts across the border. They also continuously confront the difficulties of working with allies on the other side of the border that have very different levels of financial support and organizational capacities.

The few border nonprofit organizations that have focused on cross-border health issues have concentrated primarily on information campaigns, especially involving cultural or behavioral issues. They include media programs on preventive measures related to HIV/AIDS, unwanted pregnancies, sexually-transmitted diseases, and domestic violence. In only a few cases, such as Project Concern and the Bilateral Safety Corridor Coalition, have groups been able to establish parallel activities on each side of the border. Planned Parenthood, to use another example, has established a binational network to deliver services in both San Diego and Tijuana, and several organizations that focus on substance abuse also have information campaigns and clinics on both sides of the border. See Appendix C for a list of border area and migrant-serving nonprofits in the healthcare area.

Truly, cross-border programs remained blocked by a combination of problems. First, cross-border activities depend heavily on a small number of "bridge builders." These leaders, and the interests they represent, rest on the margins of the primary organizations and their main strategies. Second, financial support directed specifically at cross-border activities is rare. Leaders of these fledgling organizations often believe they have better opportunities for funding with their own national governments, and, to a large extent, they have accurately diagnosed their financial environment. Third, groups along the border often define their organizational interests and identities, if not their issue areas, strictly in national terms. It is not rare, for example, to have community-based organizational leaders in Mexico advocate for a Mexican approach to the border and the time and resources to mobilize "on

their own” before joining forces into a cross-border singular entity.

Finally, many leaders of community-based organizations along each side of the border believe it is too difficult and perhaps “premature”, as one program director in Tijuana explained, to take on cross-border issues that will run afoul of either Mexican or U.S. government policies on border affairs. Immigration policy tends to be the most frequently cited problem, but the costs to health care systems in the United States and the inflexibility of health care resources in Mexico also top the list.

When governments become partners with these civil society organizations, their activities of course can grow. U.S. and Mexican officials, for instance, have included a role for community organizations in their binational tuberculosis campaign. Through the USMBHC, they are also working together to establish internet communications among various workplace treatment and education programs as well as the establishment of confidential links among health professionals sharing research and treatment information to improve the efficiency of their work. Unfortunately, the record provides little evidence that these activities or relationships have sunk deep roots into border communities because these innovations are costly and time-consuming to create. Improvements in the capacities of community-based organizations in Mexico especially have stalled but at least communication between Mexican and U.S. leaders is strong and this area is fertile ground for the investment of the private and non-profit sector resources because the benefits accrue to the whole of both countries.

In the last few years, the Mexican government has reached out to civil society organizations to forge a public-private partnership on health issues related to the Mexican community in the United States. The move represents a valuable innovation in attempting to overcome the institutional mismatches common at the border. In a real sense, the Mexican government has decided that its jurisdiction extends beyond its borders to reach members of transnational communities who reside in the United States. An example of such a collaboration is the California-Mexico Migrant Health Initiative with active participation from the highest levels of both the Mexican government, the State of California and the University of California.

Although these programs have received broad public recognition, they remain small scale and tenuous. Mexican government involvement with its

citizens living in the U.S. has at times been criticized by media and some politicians as meddling in U.S. affairs. Without support of the U.S. government, the Mexican government’s authority in the transnational community remains weak. The lack of a history of cooperation between government and civil society in Mexico has also reinforced skepticism among Mexican community members in the United States for any government-led initiative. Others have also worried that the Mexican government’s focus on the part of these transnational communities residing in the United States has served to weaken its resolve to respond to the needs of the origin communities inside Mexico.

D. Cross-Border Projects

The search for a sustainable cross-border health-care strategy differs from the above policies because its primary focus is on the way in which people organize their community life across borders, rather than the limits and needs of the institutions that work on either side of the border. The goal of such a project is to create and sustain a “virtuous cycle” that matches the circulation and connections of movements back and forth across the border, between the ways in which the health-related risks occur, project activities may occur. These cross-border strategies would seek improvement of conditions at home in Mexico and in the linked U.S. communities. Although specific project interventions may occur at various locations in Mexico or the United States, they must have linked connections to complementary efforts throughout the binational region. Few examples of such projects exist from which to compile a list of positive and negative attributes or practices from which to develop a comprehensive binational regional strategy. Innovative financial arrangements would also be needed to provide incentives throughout the community to maintain participation and commitment.

However, the ICF forum of healthcare practitioners supported several key principles from which to begin a strategic design. First, the strongest resistance to working in a way that reaches throughout a cross-border community is the uneven distribution of finances. Without a process of project development that allows people or representatives on both sides of the border to participate, whoever controls the project money becomes a dominant leader. This *de facto* designation of a leader can generate opposition or, in most cases, a simple refusal to participate in the initiative from the outset. A common fund, rather than separate budgets, could respond to and help overcome this concern.

Second, the difficulties of simply getting people from each side of the border to cross and work together day-to-day must be overcome. Like other developing community-based organizations, direct interpersonal connections are important. So too is an expectation that the outcomes of a project will be considered successful only if there are improvements throughout the community – in this case, on both sides of the border. Joint project development, including clear performance measures that require reciprocal gains, could provide the discipline to reinforce working together as opposed to separately. This is another goal of the USMBHC but which progresses slowly for obvious reasons.

Third, sharing information, supporting common positions, and solidarity campaigns are not enough to generate and sustain the community connections in a cross-border environment. In a sense, projects need to be transnational in their design, addressing a problem that is truly a cross-border issue. Health care infrastructure provides a good example. A project could target the inequality between the two sides of the border in health care expertise and facilities by designing and developing ways to share diagnostic and treatment assets through new long-distance technologies. Improvements in health care in Tijuana could be matched with reductions in emergency health care costs in San Diego but these benefits go beyond the border for the border is a gateway to both countries. As such, solving health problems when they are relatively containable at the border can prevent the cost in lives and other resources that the spread of a pandemic could bring to the interior of both countries.

Fourth, several existing institutions may have greater potential and capacity for working across borders than what can be achieved by building new programs from the ground up. For example, unions, church organizations and service clubs (Rotary, Lions, Shriners, etc.) have a history of members working on small projects across the U.S.-Mexico border. The union agreement in San Diego that allows workers to select the Mexican government's health insurance coverage as part of their benefits package is a good example of how, by working with community members' own interests and practices, existing institutions could be reshaped into a binational, regional program.

These principles may help form the foundation of the design of cross-border projects. By themselves, however, they need to be incorporated into a more comprehensive planning process and mo-



Photo Credit: ICF

bilization campaign. They could be instrumental in forming a leadership team that, as seen earlier, is instrumental in scaling up healthcare efforts. These principles, and an organized leadership team, could be a first step in creating a strategic vision that is rooted entirely in innovation, of reaching for a scale that perhaps few in the region have yet to realize is needed, and to overcome the barriers to health-care institution building that are deeply rooted in existing, but alterable, jurisdictional preferences. Leadership must come from the border where the experiences that will bring health and healthcare abide and must then reach out to the leaders of both countries since any health threat to the border previews threats to the whole country or countries.



PART IV

A STRATEGIC AGENDA FOR CROSS-BORDER HEALTH

The core strategic question facing the binational, San Diego-Baja California region is straightforward: “What can be achieved together that can not be done alone?”

Obviously, difficulties working together across borders should not be underestimated. Years of dedicated labor have generated only a small number of success stories. Still, cross-border community health is a challenge whose time has come. Its origins, problems and future are linked fundamentally to the processes of globalization and cross-border regionalization that have only begun to take shape. It is the way that people are experiencing their health risks both as they move across borders at ever increasing rates and as community members exposed to these changes.

The geographical scale of the issue is not, however, the primary policy challenge, although any time communities become stretched over long distance many problems arise. Rather, the core policy issue involves fundamental questions of democracy and representation – to which government jurisdiction and to which health institutions can a person



living in a cross-border community expect to have access? The answers certainly require program and service innovations, but they also require a willingness and ability of political leaders to work across non-traditional lines of program authorities, to reach across borders, and to engage constituencies in new ways. A cross-jurisdictional approach to community health pays off in the end with improved health for an entire community, greater economic productivity, and lower fiscal burdens.

Although some may think otherwise, regional political leaders can not succeed working alone. They need to increase the level of community participation as effective partners in the policymaking process. Whether situated in San Diego or Baja California, leaders from all sectors need to engage around community health issues that educate and mobilize the region’s residents. Civic engagement is key to successful health solutions. Unfortunately, educational outreach programs are often too small and ineffective on both sides of the border. Political leadership at the elite and grassroots levels need to build health campaigns that both alert and educate the entire region to seek appropriate solutions.

The financing of regional health programs can also not be done alone. Local initiatives are unlikely to be sufficient to support the scale of required activities. Communities, governments, and institutions in both San Diego and Baja California can become advocates for new financial mechanisms, investments, and innovative programs design that will generate more resources, expand access, and improve the health of entire communities so the costs for individuals declines. Pooling resources and programs can be much more effective than duplicating or dividing costs.

Political leaders on both sides of the border also need to work together to attract the attention and resources of higher levels of government. Currently, regional leadership remains encumbered by persistent, traditional financing approaches that seek reimbursement for health costs from federal governments. Throwing the health care costs of the binational region at the foot of overly pressed federal governments does not work. Similar federal reimbursement programs for criminal justice costs, for instance, have been riddled with problems. In the end, when federal dollars are no longer available, the absence of local, binational engagement means that little has been done to change the health conditions and behaviors that continue to generate the costs.

The time for innovation and large-scale reforms, then, has come, and they will not be achieved by working alone. Even the best health programs today are structurally limited and often organized for failure. By leaving entire sections of the continuum of care unattended, even good program interventions on selected areas will be overwhelmed by repeated exposures to risks and recurring ill health. Most innovative programs are also simply unable to “go to scale,” relying on annual fundraising campaigns or piecemeal program budgets designed around “pilot tests” rather than systemic intervention.

The binational region needs a new start, a new strategic vision that is as encompassing and bold as the problems it seeks to solve. The region needs a call to action that excites the enormous innovative spirit of the region and mobilizes the considerable assets and talents of residents on both sides of the border. One way to begin is to call leaders throughout the region together for a Health Summit. It would only be a start, but it is long overdue. Building an agenda for the Health Summit would begin a deliberation, carried on throughout the region, that ends up with a list of objectives and solutions around which the best of the binational community could be mobilized.

The following section provides four categories of exemplary issues that could be pursued in the Summit and the healthcare campaign that hopefully would follow. These examples are included here only to help stimulate discussion. The intent is to focus the debate on large-scale reforms and initiatives that would reach levels of a strategic vision that encompasses the widespread and unmet needs of the entire region.

1. Getting Started

Recent declarations from the mayors of San Diego and Tijuana expressing interest in revitalizing a cooperative relationship on cross-border issues could help jumpstart increased attention to the binational character of health issues. Beyond what the Mayors would choose to take on, what are some immediate policy issues that should be addressed? The following provides a few suggestions.

- **Support the Border Health Security Act and revised implementation.**

U.S. federal legislation that seeks to improve the infrastructure, access, and delivery of health care services to residents along the U.S. should be strongly supported. The Act historically has provided substantial resources to border communities in ways that allowed flexible decisions about local priorities and use. It has also funded the U.S.-Mexico Border Health Commission (USMBHC).

Implementation of the Act, however, could be significantly altered. While local engagement is a key to successful action, local communities need to focus on building comprehensive strategies, especially including cross-border initiatives and designs. USMBHC could play a more aggressive role in going beyond identifying lists of priority diseases and work with communities to overcome the barriers to cross-border programs. The USMBHC has a prominent role as catalyst in education policy makers at all levels of the community and government.

- **Reinvigorate the San Diego-Tijuana Binational Health Council.**

Once active in convening border area health practitioners, the San Diego-Tijuana Binational Health Council (a chapter of the USMBHA) now lays organizationally dormant. The need for such a network is now more important than ever before. Health-focused nonprofit organizations in both San Diego and Tijuana are working virtually independently and isolated, with limited coordination to

increase opportunities for synergy and economies of scale. A revitalized Council could also ensure representation of all segments of the region at the local level, providing a mechanism for dialogue and coordination across the border and between various social and professional groups and community based organizations among the nonprofit sector, academia and business. It has received grants from the USMBHC to develop an administration and communications network but more sustained resources are needed.

- **Support Expanded Cross-Border Health Research**

A key finding of Forum participants and reaffirmed in the NLRC study was the importance of on-going research on cross-border health issues. Without hard data and local health indicators it is difficult to make the case that additional support is needed. Here, the San Diego-Baja California region is blessed with leading academic institutions (UCSD Medical School, SDSU School of Public Health, USD School of Nursing, UABC Medical School) that are in many cases already undertaking work on a wide range of border health issues but expanded funding is necessary as well as greater collaboration with border area nonprofits with established ties to the communities most in need of attention. Without a doubt, there is a unique opportunity for expanded research that could positively benefit people and communities far beyond our region.

- **Leverage Technology**

Telemedicine-based projects exist between San Diego and Tijuana that hold considerable promise for leveraging the enormous human capital and technology potential in San Diego to improve the health care situation in Baja California. These small projects should be reviewed to see what it would take to scale them up to a level that would have a meaningful impact on the health care status of Baja generally. If the promise could be realized, public and private efforts should be made to enlarge them. Another way in which technology can assist binational collaboration is the routine use of video-conferencing equipment for binational meetings. Many participants in our March forum stated that, because of the long border delays, it is very hard to attract equal participation from Mexico if a binational meeting is held in San Diego and same is true for U.S. participation for a meeting held in Tijuana. Using video-conferencing equipment now available in many locations on both sides of the border would

increase participation and guarantee true binational input.

- **Expand Emergency Health Services**

With an expansion of the number of people living, working and retiring south of the border, the region needs to expand and modernize its delivery of emergency health services. Opportunities exist for expanded for-profit, cross-border transportation of sick or injured US residents from Mexico to this country, a service that is currently solely provided by the Binational Emergency Medical Care Committee, a volunteer led non-profit organization with a good track record but with on-going challenges to respond to future demands. Part of the modernization and expansion challenge is to find ways to improve the efficiency of getting across the international border. Federal inspection authorities in Mexico and the United States obviously have legitimate reasons for regulating the movement of emergency ambulatory vehicles. With modern technology and new security procedures – such as SENTRI – a plan to facilitate cross-border transport can feasibly be accomplished with the help of the US consulate in Tijuana and the Mexican consulate in San Diego. Local and federal border authorities must be engaged in the plans to facilitate health related people and equipment crossing bi-directionally.

- **Formalize Cross-border Anti-Human Trafficking Protection Teams**

The Baja California - California binational region suffers from the health consequences of human trafficking, informally indentured work, and abuse. Some of these problems are due to formal, organized smuggling. Others arise from the household dissolution that occurs in labor markets in which members of a family are separated by long periods of time and are often completely dependent on wages generated by another member. A promising binational regional initiative currently is working effectively on a small scale with police and other authorities on both sides of the border. More effort on building and expanding capacity could create a model of taskforce cooperation between community and police that works directly on crossborder activities.

- **Re-design Disease Specific Programs**

Many diseases, from tuberculosis to HIV/AIDS, thrive on the circulation of people back and forth between U.S. and Mexican towns. Even when treatment is offered on one side of the border, continued care is uncertain as the person continues to move around the region. Current attempts to monitor and share information on tuberculosis patients, such as the CureTB program of the San Diego County health department, provide important examples of what can be done. The USMBHC has created a health card with the cooperation of more than 40 entities working in tuberculosis care that enables patients to keep treatment going as they traverse the border back and forth. The USMBHC also supports a Directly Observed Therapy Program in Tijuana to ensure patients take their medications every day. Continuing basis and less costly drug therapy saves \$150,000 every time a patient is treated without the highly expensive multi-drug resistant regimen.

With tuberculosis as with many other common border illnesses, there is the ongoing struggle with reduced funding and overly complicated administrative requirements. The binational region as a whole has a strong self-interest in making these programs successful. Efforts to raise their visibility and expand them could be taken on at all levels of government and in institutions throughout the region. This would save lives and resources for both countries.

- **Provide Healthcare for Contract Cross-border Workers**

Recent national attention to the contributions of migrant labor systems to both the U.S. and Mexican economy continues to have a fatal flaw. The health of these workers and their families is fundamental to their successful contributions. Yet, the health dimensions of the migratory flow are largely ignored in proposed legislation. The San Diego-Baja California region has a substantial stake in both the labor and health conditions of its workers, on both sides of the border. It is in the local interest, therefore, to ensure that a guest worker program or its equivalent have provisions to serve migrant workers and protect the regional community from health risks.

What can state and county level organizations do? Private sector leadership, public incentives, and community support should encourage companies that employ migrant workers to provide health coverage, including encouragement to the workers to enroll in one of several cross-border health plans now available (e.g. BlueShield, HealthNet and PacifiCare). These plans are often thirty percent less expensive than traditional health plans and, if the workers gain legal status, they will be more likely to participate because they can move freely back and forth between their worksite and where they will get the care.

- **Moving Beyond Crisis to Prevention**

All too often public compassion and attention to border health issues tends to swing towards the most recent headline grabbing crisis—Tijuana’s alarming increase in HIV/AIDS or the city’s flood victims—but little attention is focused on prevention and preparedness. As Melissa Berman, CEO of Rockefeller Philanthropy Advisors notes, “conditions don’t make the news. Crises make news.”⁴⁴ The experience of most border health oriented nonprofits participating in ICF’s recent forum observed that it is easier to raise money in response to a crisis than for health care & disaster prevention yet the cost savings and societal benefits could be substantial if there were greater focus on prevention and preparedness.

Moving beyond crisis to prevention will require leadership. Recognizing that many of the border’s emerging health crises can be more effectively managed and, in some cases, prevented with a more involved and engaged public, communications is critical. Media coverage is critical and yet more often than not, critical border health related news stories, particularly those directly impacting Tijuana, are seldom covered through San Diego news outlets until there is a crisis. Here, border area nonprofits must do a better job of communicating critical cross-border health needs to the media on both sides of the border. After all, if the media, especially TV, does not cover an issue, few border residents will know of its importance.

2. Financing Cross-border Health

With the possible exception of the legal issues related to border crossing, the primary problem for

⁴⁴ Epstein, Keith, “Crisis Mentality: Why sudden emergencies attract more funds than do chronic conditions, and how nonprofits can change that,” *Stanford Social Innovation Review*, Spring 2006, p53.

the region is how to finance cross-border health initiatives. As described earlier, the persistent inequality in assets nearly dooms cross-border efforts. The key to the financial challenge is to find creative new ways to generate resources that come from the activities of the regional economy and assure that local border communities have the authority to control and determine the use of those resources. Some ideas for generating new revenues include:

- **Border Crossing Fee**

The idea of a border crossing fee, of course, has been around for years and received mixed support. It has failed for many reasons, including disagreements over how the revenue will be distributed, the amount of the fee, and competing uses of the collected money. The time may be right, however, for a plan that used a border crossing fee to generate funds for binational health programs. The fees would be placed under the authority of an independent regionally focused health commission, and a cross-border leadership team, to be spent on health priorities throughout the region. Other potential resource generating opportunities for health programs may be found in the private sector. Improved health is a direct investment in the cross-border economy that will produce a return benefiting local small and large businesses alike.

- **Catalyze Private Sector Solutions**

The private sector is well positioned to dramatically expand the level of cross-border health coverage available to both U.S. and Mexican residents. Already an estimated 150,000 California based employees have cross-border coverage through one of three existing plans: Blue Shield of California's Access Baja plan, HealthNet and SIMNSA. With the growing number of U.S. residents now retiring or moving to Baja California, new opportunities exist for expanded telemedicine health diagnostic screening permitting patients to receive basic care in Mexico as well as improved private sector health care options for this growing market segment. As more people from each side of the border moves to the other, opportunities to improve and equalize quality healthcare options throughout the region will increase. Tijuana's new Hospital Angeles has positioned itself to service this growing demand for private-pay consumers from the U.S. and Mexico and other providers are sure to follow.

- **Pilot Test U.S. Medicare Eligibility across the Border**

Nearly a decade ago, the idea was proposed to create a pilot project to permit otherwise eligible U.S. residents now living in Baja California to obtain health care in Mexico that would be reimbursable to the Medicare program.⁴⁵ Now, with funding for Medicare even more in crisis than before, the time is ripe to test the value of making Medicare portable for the growing number of U.S. senior citizens that are now living in Baja California due, in part, to their inability to afford the cost of a comfortable retirement in their own country. The pilot is a natural opportunity for a research and demonstration project waiver from the federal Health Care Finance Administration (HCFA), but could also be supported through direct legislation. The potential cost value of such a program would have immense financial implications along both the U.S.-Mexico and the U.S.-Canadian borders. A similar demonstration project can be developed to test the feasibility of the Medicaid program also covering the cost of services by certified providers in Mexico.

3. Cross-border Health-Oriented Security Program

The recent decision by federal Department of Homeland Security (DHS) to drop San Diego from its list of metropolitan areas qualifying for its Urban Areas Security Initiative (UASI) funding demonstrated the weakness in the region's ability to build a comprehensive approach and to advocate as a united binational mega-metropolis for the sake of its own economic well-being and security. DHS' decision included not only an assessment of the risk the region faced, but it's need and plans to meet those needs. Cross-border public health preparedness offers San Diego an innovative and vital strategic target for homeland security preparedness. The potential risks are undoubtedly high. Given the lack of health infrastructure on both sides of the border, the need is certainly great. The challenge for San Diego is to craft a strategy that effectively prepares the binational region to meet these health-based security risks. From medical surgical capabilities to alternatives to border closures, San Diego could lead the way in designing an approach that would meet its own needs and offer critical lessons for other border communities. There is currently a cooperative taskforce involving federal, state and

⁴⁵ Warner, David, "Health and Medical Care in San Diego and Tijuana: Prospects for Collaboration: Briefing Paper prepared for San Diego Dialogue, December 1999., page 14.

county public health workers to design a strategy for border security and training. This plan would not only serve in time of crisis but would boost the sadly lacking public health infrastructure needed for every day health problems. This would be an efficient and rewarding system for today's and tomorrow's needs.

- **Craft a Cross-border Health Surveillance Initiative**

Using health-related funds for homeland security, the binational region could greatly expand the CDC-funded "Binational Infectious Disease Surveillance" (BIDS) program in order to complement existing local program initiatives and volunteer cooperation with Mexico and other foreign governments. As the SARS and Avian flu cases demonstrate, early detection and coordinated response will save lives. Thorough surveillance will inform fair and timely allocations of national and global health resources and strengthen government accountability in responding effectively.

With these goals, surveillance systems should at least be partially independent of the governments which fund them. Reluctance to report and to thoroughly analyze symptoms and evidence costs lives. A binational, health surveillance system, built around community involvement in reporting could provide a sustained awareness of persistent and emergency health problems throughout the cross-border region and regardless of jurisdiction. Inter-agency cooperation within Mexico needs to be improved as well as binational communications protocols developed and tested to assure they will work in an emergency.

- **Foster Dual-Use Programs**

Health-related homeland security requires not only special projects but a sustainable approach to building comprehensive infrastructure and capabilities to achieve a desirable state of preparedness. Much of that infrastructure and many of the capabilities have multiple uses. While they must be able to surge at times of threat, preparedness also means that the community increases the quality and quantity of its available assets for every day uses. The binational region should use this opportunity and the imperatives of security for the entire San Diego-Baja California area to establish the cross-border framework and rules to make healthcare programs effective. For example, the region needs facilities to adequately test suspicious substances, diagnosis disease, and respond in both preventive and miti-

gation modes. Those facilities and the network of scientists, physicians, and emergency responders should be organized in a cross-border plan that does not require complicated negotiations or competitive demands for future funding. This may also be an opportunity to move to accredit and credential health officials on both sides of the border under similar rules, which would greatly enhance programs designed to allow professionals to contract their services to needy communities on both sides of the border. The beginning of planning such an elaborate cooperative is currently underway but in need of more support and resources.

4. Cross-border Private Sector, Civil Society Capabilities Initiative

The needs in the San Diego-Baja California border region are great and most active health oriented nonprofits are ill prepared to sustain their current activities without additional support. Due to budgetary downsizing, traditional sources of funding are being cut so many area nonprofits face growing demand for services with a corresponding decrease in available funding. Although numerous specific programs could be supported, a comprehensive initiative could begin with the following types of activities.

- **Create a Cross-Border Health Fund**

San Diego grantmakers need to come together to establish a regionally focused cross-border health fund to catalyze philanthropic resources to tackle emerging issues. Funders need to be far more proactive on border health issues. The Fund could help tackle the more difficult issues, often involving policy changes and overcoming the systemic barriers mentioned earlier that governments would be less able or willing to pursue. A Cross-Border Health Fund could also support the leadership, resource team that could help bring the region through the strategic, scaling up process.

- **Innovation**

The San Diego-Baja California region has long been known for its innovativeness. Now is the time to focus that capability on health care. From technological ideas to community-based mobilizations, the region has an untapped capacity to create new, more effective ways of overcoming seemingly intractable problems. The region also frequently serves as a test market for new products, reflecting outsiders' expectations of the uniqueness and openness of the area's population to improvement. The

economic development and innovation centers that currently exist throughout the region should turn part of their attention to the healthcare issues.

- **Private Sector Leadership**

From the ownership of 85 percent of infrastructure critical to homeland security to the recognition of leaders of community organizations, the private sector holds the key to change throughout the cross-border region. Organizations, such as the San Diego Regional Chamber of Commerce and Tijuana's Centro Coordinador Empresarial de Tijuana (CCE), have the potential to coordinate San Diego and Baja California area businesses. Individual businesses also have clear incentives to invest in the area to enhance their own performance. Yet, specific leadership engagement is still absent. Private businesses need to identify or craft appropriate and acceptable channels of participation in areas where, although their role may be critical, how they can be successful remains unclear.



PART V

A SHARED DESTINY: A CALL FOR ACTION

The San Diego-Baja California region faces some significant cross-border health care challenges in the coming years, which if left un-addressed, could have irreparable consequences on the regional economy on both sides of the international border.

Clearly, more can and should be done by governments to better coordinate initiatives at the local, regional, state and federal levels. Governments, however, are not in a position to address the growing trans-boundary health care challenges alone.

Recognizing the critical importance of the region's binational health issues and the existing institutional impediments to effective programs, ICF is calling on the area's leaders to take urgent action. If our binational region is to effectively address our future health care challenges, greater cooperation will be needed by the private sector, government, academia, the nonprofit sector as well as funders (individual and foundations) committed to making a difference. The most knowledgeable border experts know unequivocally that leadership in border health must be situated at the border for the well being of

not just those living at the border but the citizens of both the United States and Mexico. Unfortunately, exchange of critical health problems can seriously undermine any success in economic and other societal problems.

Where policy reforms are needed, there is a pressing need for stakeholders in our border region to work more closely together in the area of public advocacy to press for critically needed changes to improve the quality of care and reduce the public health risk of our residents. Where potential policy solutions exist, there is critical role for philanthropy from both sides of the border to play in funding research that can provide the needed data to validate critical needs and substantiate proposed policy reforms.

A concerted effort must be made to identify the business case for more pro-active private sector involvement in responding to critical cross-border health needs particularly in the area of leveraging technology (e.g. telemedicine) or financial solutions to improve binational access to care. Finally, given the scarcity of resources currently supporting border health initiatives, there is a critical need for greater communication and collaboration across the sector.

The San Diego-Baja California border region faces a number of critical cross-border health challenges which could be effectively addressed through changes in public policy or administrative actions at the Federal levels of government in both the United States and Mexico. Yet, to shape change it is critical that border area health practitioners get more engaged in public advocacy helping elected officials and other key decision makers about ways that changes in policy can reduce health risks along the border.

While San Diego-Baja California's healthcare needs are well documented and several near term actions have been identified as priorities in this report, there is a pressing need for key decision-makers to come together to formulate strategies for expanded cooperation and engagement. Here, ICF recommends the key public, private and nonprofit decision-makers come together soon at a cross-border health summit to examine critical issues and develop an actionable plan aimed at dramatically increasing the level of attention and commitment to cross-border health issues in the region.

As one of the few local public charities in the border region with a cross-border philanthropic mission, ICF is committed to playing a pro-active leadership role to elevate border health issues as a priority to key decision makers in the region. Leaders from all sectors must see first-hand the cross-border health risks, priority needs, and efforts that can make a difference. All too frequently, the region's leaders have little direct experience with communities on the border. Towards this end, ICF is committed to organizing a series of leadership tours to highlight border area health needs and opportunities on both sides of the border.

Much work remains to be done but working together with key stakeholders from the public, private and nonprofit sector as well as funders and readers like you, systemic changes are possible that will, over time, improve the quality of health among all residents of our border region irrespective of socio-economic class, nationality or immigration status.

ICF invites you to join in these efforts -- border health issues really do matter. The status quo is simply not acceptable. Waiting for further deterioration in public health or for a flu pandemic to prompt action is betting with the future of the region and the lives and well-being of rich and poor alike. Whether one lives in a gated community or in informal housing with limited basic infrastructure and

no running water, the residents of the San Diego-Baja California region share the same air, shopping malls, public and recreation spaces, public transportation systems, workplaces, and even the same restaurants. The state of our region's border health is only as sound as its weakest link. Even today, the economic consequences of rising health costs and reduced productivity, combined with potential border closures from quarantines, are simply far too great to ignore.

Regardless of what side of the border we occupy, when it comes to public health issues we share the same destiny. We should do all we can to ensure that our destiny is one of our choosing and good for one and all.



Children at Hospital General de Tijuana. Photo Credit: Amy Carstensen, ICF.

Appendix

Appendix A: Bibliography

Appendix B: List of Forum Participants

Appendix C: Listing of Cross-Border Health
Nonprofits Organizations.

Appendix A: Bibliography

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Promotora Workers, Fronteras Unidas Pro Salud, Tijuana. Photo Credit: Saytel Lopez, ICF.

Appendix B: List of Forum Participants

Shared Destinies Forum:

Health in the Cross-border Region

March 30, 2006

Attendee List

Mr. Robert Bach, ICF Advisor (Moderator)
Ms. Julie DeBenedetti, Sharp Healthcare
Ms. Marcela Deffis de Rosas, Fundación Codet, I.B.P.
Ms. Cecilia Diaz, Binational Emergency Medical Care Committee
Mr. Steve Eldred, The California Endowment
Ms. April Fernandez, California Office of Binational Border Health, CDHS
Ms. Laura Hernandez, Sharp Healthcare
Mr. Ricardo Jimenez, Health Care Consultant, formerly with the CA Office of Binational Border Health
Dr. Rosemarie Johnson, USMBHC Commission
Ms. Elizabeth Jones, Hospital Infantil
Mr. Richard Kiy, International Community Foundation
Ms. Linda Lloyd, Alliance Healthcare Foundation
Dr. Blanca Lomeli, Project Concern International
Dr. Maura Mack, California Office of Binational Border Health, CDHS
Mr. Ed Martinez, San Ysidro Health Clinic
Ms. Chelsea Monahan, International Community Foundation
Mr. Juan Olmeda, Office of Border Health, County of San Diego
Ms. Liliana Osorio, California-Mexico Health Initiative
Mr. Cesar Portillo, Advocacy Works, LLC
Mr. Alfonso Rodriguez, California Office of Binational Border Health, CDHS
Ms. Janine Schooley, Project Concern International
Ms. Rosana Scolari, San Ysidro Health Clinic
Ms. Lori Senini, Office of Border Health, County of San Diego
Ms. Amelia Simpson, Environmental Health Coalition
Ms. Marisa Ugarte, Bilateral Safety Corridor Coalition
Mr. Sid Voorakkara, The California Endowment



Fundación de Apoyo para Niños Especiales, Tijuana, B.C., Photo Credit: Amy Carstensen, ICF.

Appendix C: List of Cross-Border Health Non-Profits in the San Diego-Tijuana Region

American Cancer Society
American Diabetes Association
American Lung Association of San Diego & Imperial Counties
Apoyo, Estudios y Servicios para la Mujer y el Niño, A.C.(Grupo Apoyo)
Asociación Pro-Salud y Bienestar Infantil Carita Feliz, A.C.
Binational Safety Corridor Coalition (BSCC)
Border Health Education Network, UCSD
California-Mexico Health Initiative
Centro de Promoción de Salud Esperanza, A.C
Council of Community Clinics
Cruz Roja Mexicana
Drug-Free Border Coalition
Environmental Health Coalition
Flying Samaritans
Fronteras Unidas Pro Salud, A.C. (Pro Salud)
Fundación Codet para la Prevención de la Ceguera, I.B.P.
Fundación para la Protección de la Niñez, I.A.P.
Hospital Infantil de las Californias, I.B.P.
(Foundation for Children of the Californias)
Institute for Public Strategies
La Maestra Family Clinic
La Vereda de la Vida, A.C.
Los Niños de Baja California, A.C.
North County Health Services
Patronato Pro Hospital Civil de Tijuana, A.C./Hospital General de Tijuana
Planned Parenthood of San Diego & Riverside Counties
Programas de Medicina Social Comunitaria, A.C.
Project Concern International
Promoción y Docencia, A.C.(Centro de Servicios Comunitarios UIA)
Proyecto de Consejo y Apoyo Binacional, A.C. (PROCABI)
Rancho Cultural Tepeyac, A.C. (Casa Guadalupe Villa de la Paz)
Rescate Tijuana, A.C.
San Diego-Tijuana Border Initiative
San Ysidro Health Clinic
Southern California Border HIV/AIDs Project (a collaboration of San Ysidro Health Clinic and UCSD's Center for Community Health/Division of Community Pediatrics)
Unidad Rosa de Saron, A.C



Patient at Hospital Infantil de las Californias, Tijuana.
Photo Credit: Foundation for the Children of the Californias.



International Community Foundation
11300 Sorrento Valley Road, Suite 115
San Diego, Ca. 92121
tel: (858) 677-2910
fax: (858) 677-2918
www.icfdn.org