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Health and Medical Care in San Diego and Tijuana: Prospects for Collaboration

Briefing Paper

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Introduction

The region encompassing San Diego County and the portion of Baja California that includes Tijuana, Rosarito and Ensenada is distinctive among metropolitan areas on the U.S./Mexico border in that the population on the U.S. side is significantly greater than the population on the Mexican side. San Diego County, with a population of 2.88 million, and the *municipio* of Tijuana, with a population of 1.21 million, have both experienced rapid growth in recent years.[1] When the neighboring population centers of Ensenada (315,000), Rosarito (46,000), Tecate (62,000) and Mexicali (696,000) on the Mexican side and Imperial County (143,000), Orange County (2.8 million), Los Angeles County (9.73 million), and Riverside County (1.51 million) are included, the overall population amounts to almost 20 million.[2]

By 2010 the San Diego/Tijuana area is projected to have a population in excess of 5 million, while the larger area is projected to grow somewhat more slowly. The San Diego/Tijuana area is distinctive also in its degree of interdependence and interpenetration of populations. Partly because San Diego County has almost the least affordable housing in the United States in relation to its wage levels, there are many American citizens and many others entitled to U.S. benefits—such as Social Security, retirement income and even unemployment compensation—who live on the Mexican side of the border. Similarly, many Mexican citizens live and work on the U.S. side of the border. There is a great deal of travel across the border in both directions to visit families, shop, purchase health services, enjoy recreational activities and look after personal and business affairs.

This degree of interpenetration and this large and rapidly growing population base pose both challenges and opportunities from both a public health and a medical services perspective. Indeed, both sides of the border face problems in providing seamless public health services, arranging for adequate and appropriate medical care for all workers, providing appropriate cross-border coverage for retirees and dependents, and finding a way to cooperate in medical education, culturally appropriate medical care and medical practice. Failing to meet these challenges will, in time, erode the region's attractiveness and affect the region's economic competitiveness. It will also forestall economic development projects in Mexico with a great deal of potential, such as making the Pacific Coast of northern Baja California a major retirement destination.

This paper was written to provide a guide to some targets of opportunity for business, governments, health providers and medical educators in San Diego and Tijuana. The first section identifies a number of public health issues that affect or threaten citizens of both cities and the status of collaborative efforts to address them. The second section examines attempts to provide adequate and appropriate medical care for all populations, with particular reference to persons who are living, working or using medical services across the border from their place of

citizenship or residence. This section looks at cross-border utilization of health services, cross-border health insurance coverage and development of cross-border health care delivery systems. The third section looks at the possibility of Medicare and some Medicaid coverage for retirees who live in Mexico. If such coverage were available, then the development of major retirement communities and medical facilities in Baja California south of Ensenada would be more feasible. The final section of the paper discusses the North American Free Trade Agreement (NAFTA) and the potential for enhanced cooperation in the delivery of medical care and medical education in the cross-border region.

Public Health Issues

Public health concerns are of great importance on both sides of the U.S./Mexico border. Joint and cooperative efforts in fighting communicable and preventable disease, in developing health education and health promotion initiatives, and in guaranteeing the quality of laboratory testing, pharmaceuticals, and food are enterprises that state and local health departments on both sides of the border can endorse. In addition, air and water quality must be dealt with binationally since they are both determined binationally. From a public health standpoint, San Diego County and Tijuana are a single "catchment area," even though services and regulations are not currently organized on a binational regional basis.

1. Communicable and Preventable Disease

Issues surrounding communicable and preventable diseases are a concern on both sides of the border, since many of the region's residents lack access to primary care and since diagnosing and treating many problems systematically in a binational population can be difficult. Some of the primary conditions of concern include tuberculosis, HIV-AIDS, hepatitis A, B and C, venereal diseases and diseases preventable by immunization. Continued and enhanced cooperation between the two sides will be required to make prevention efforts, diagnosis and treatment in the region much more consistent and continuous.

Tuberculosis in San Diego and northern Baja California has been a concern for some time. Its seriousness, difficulty in diagnosing some cases, rate of contagion and requirement for extended treatment all make TB a particularly challenging condition. In the San Diego/Tijuana region, TB occurs in a binational context, in which many of those infected cross the border or come into contact with residents from the other side of the border. Drug-resistant TB is a special concern on the Mexican side, because some drugs are freely available through pharmacies and many infected persons may have started treatment but not completed it. There are also problems related to the affordability of treatment, because of the limited resources available for persons needing four or five expensive drugs in order to be treated properly.

A number of efforts are currently under way to address the issue of drug-resistant TB in the border region. Both local health departments have worked on this problem and a series of grants, first from the Robert Wood Johnson Foundation and currently from the California Endowment and the Alliance Healthcare Foundation, have supported development of enhanced laboratory capacity, outreach and treatment of drug-resistant TB in Mexico. The California State Health Department has funded a toll-free phone number administered by the San Diego County Health

Department as part of a program called CURE TB, which arranges case-finding across the border and provides referrals throughout Mexico and in the United States for treatment.

In addition to the health departments, Project Concern International, along with its affiliate in Tijuana, *Medicina Social Comunitaria*, is involved in developing outreach efforts to educate and provide access to treatment for high-risk groups. They are developing training programs for *promotoras* (local community residents who serve as "health promoters"), who will do much of this work. The Tijuana Sanitary Health District provides TB case-finding and treatment on the Mexican side. Finally, USAID (the U.S. Agency for International Development) plans to include Mexico in a five-year, US $10 million grant to focus on TB, with some attention to be paid to the northern Mexican border.

HIV-AIDS is more prevalent in the San Diego/Tijuana metropolitan area than elsewhere along the border. A number of factors contribute to these higher rates of HIV-AIDS, including: seasonal agricultural workers who may have acquired the disease in the United States but who live in Mexico much of the year, residents of Los Angeles and San Diego, including military personnel, crossing the border to access the sex industry, and additional opportunities for users in both countries to obtain illegal drugs. Not only does higher prevalence of HIV in the area pose risks to the population at large, but if HIV really takes hold in Tijuana, the risk of more active communicable TB will become more significant as well. Many of the risk factors for HIV-AIDS are also risk factors for **hepatitis B and C**. Realistic and culturally appropriate prevention education will be especially important in confronting these diseases, as will adequate testing facilities and treatment regimens.

Record-keeping for **immunizations** is difficult when children move back and forth across the border, when the immunizations are not identical on both sides, and when parents are afraid that taking their children for immunizations might endanger the whole family's ability to become naturalized. With a coordinated effort it would be a reasonable goal to achieve a high enough immunization rate so that spread would be difficult for most immunizable diseases ("herd immunity").

2. Developing Health Education and Health Promotion Initiatives

Developing effective health education and health promotion initiatives will require cooperation in developing programs for people living on both sides of the border. In Tijuana, as in San Diego, there are significant population segments from southern Mexico and Central America with very limited education. Some efforts to target these populations, which have been developed and should be built on, include:

1. media messages and telenovelas, and
2. initiatives by hospitals and clinics to develop health promotion strategies, including the use of *promotoras* and other community health workers to provide health education and to connect individuals and families to practitioners and programs.

3. Assuring the Quality of Laboratory Testing, Food, and Pharmaceuticals

Improving or assuring the quality of laboratory testing on both sides of the border is vital. Issues involving the quality of laboratory testing include reliable HIV tests of sex workers and high-risk sexually active populations, TB testing for active TB on both sides, and routine lab tests that patients in the region can rely on and provide to their physicians on the other side of the border. Similarly, as increasing numbers of U.S. residents go to Mexico to purchase pharmaceuticals, it is important that they have assurance of quality. Finally, standards for food handling and quality are of increasing importance, as increased quantities of food are being produced by large producers on both sides of the border and more and more individuals depend on fast and processed food for many of their meals.

4. Organizational Issues in Public Health

One difficulty in coordination across the border has always been that many functions in the United States are delegated to, or even decided at, the state and local levels, while in Mexico most policy decisions have to be made at the federal level. Mexico has begun to decentralize public health budgets, and the public health workers who were formerly federal employees are now employees of the state of Baja California. However, much of Mexican health care policy is still made in Mexico City. As public health issues become even more complex—for instance, developing a San Diego/Tijuana strategy for dealing with chemical or bio-terrorism—it will become necessary to develop collaborative cross-border arrangements in advance. There are ongoing cooperative efforts that allow for the two local public health departments to work together and form relationships, but there is a long way to go before they can approach the level of coordination that a single health department might achieve.

One promising avenue for building new sustainable cross-border cooperation on public health issues is the United States/Mexico Border Health Commission Act. The act (HR 2305), which was passed by Congress in 1994, is intended to strengthen binational cooperation in public health between the United States and Mexico. It authorized the President of the United States to form an agreement with Mexico on the establishment of a binational border health commission. The commission would be charged with several duties, the first of which would be to carry out a comprehensive needs assessment of the U.S./Mexico border that would identify and evaluate existing health problems. Once the assessment was completed, the commission's responsibilities would include:

1. assisting in public and private health efforts to prevent and resolve potential and existing health problems;
2. developing and implementing programs that will educate the population about health issues; and
3. determining which of the governments would reimburse the other's public and private health care providers for the cost of services incurred by nonpaying citizens or resident aliens of the neighboring country.

The commission, which received its first appropriation of $800,000 for fiscal year 1998, provides support for investigations, general research, and studies dealing with health problems that affect the population of the study area. Three commissioners from each of the four U.S. border states have been nominated by each of the governors and are subject to approval by the secretary of the U.S. Department of Health and Human Services (HHS). For current fiscal year, $900,000 has been appropriated. The Mexican authorities have been hesitant to endorse this legislation or to

pass similar legislation because of the language in clause 3 above; they have been concerned that the fiscal implications would be onerous if Mexico had to cover medical care received in the United States by Mexican nationals.

At the cabinet level, a number of U.S. secretaries met with their Mexican counterparts in Mexico City in the spring of 1996. In this meeting U.S. HHS Secretary Donna Shalala and Minister of Health Juan Ramon de la Fuente convened the first meeting of the Health Working Group, which was established as a medium for interaction. This working group is part of the U.S./Mexico Binational Commission, which provides a regular forum for meetings between cabinet officers. The working group had an initial focus on four priority areas—migrant health, women's health, smoking prevention with a focus on adolescents, and immunizations. Subsequently, issues related to aging and substance abuse were added to the agenda. Concurrently, the U.S. Department of Health and Human Services and the Secretariat of Health of the United Mexican States have signed a memorandum of cooperation in the field of health.

Adequate and Appropriate Care for Working Populations and their Families

Both San Diego and Tijuana have significant populations that are not covered by health insurance and have limited access to medical care. There are also a number of persons in the region who seek care across the border that is more advanced, more affordable, or more culturally appropriate than the care available to them in their country of residence. For many persons with perceived gaps in their coverage, the most appropriate solution is to go across the border to seek care. Further complicating the situation are those who live in one country but work in the other country and wish to arrange coverage for their dependents. Both Mexico and the United States have introduced reforms to deal with some of the issues of cost and coverage surrounding health care provision in the border region. Improvements can come with increased cooperation, but as always, it will be important to make sure that the cure is better than the problem it seeks to address.

1. Health Insurance Coverage in San Diego

A recent study estimates that there are 645,000 uninsured individuals in San Diego County, making up about 27 percent of the non-elderly population.[3] San Diego County does not provide health services directly, but rather redirects state funds and some local tax funds as a payer to hospitals and clinics, and to fund public health activities. San Diego County has the most restrictive eligibility requirements for public health insurance coverage of the six largest counties in California. According to the study:

> Payer counties (San Diego and Orange) have stricter eligibility requirements. In San Diego, eligibility is restricted to medically indigent adults that meet low-income guidelines, are 21 to 65 years of age, are not eligible for Medi-Cal, have life-threatening or chronic conditions and are legal residents. Undocumented and new immigrants are ineligible. Primary care to these medically indigent adults through the County Medical Services program is provided only by community clinics in San Diego County. San Diego County is the only county studied that restricts eligibility based on medical severity, and

San Diego and Orange counties are the only counties that restrict eligibility to legal permanent residents.[4]

Since San Diego County does not maintain a public hospital or a network of public health clinics, it is not eligible to receive extra Medicaid matching funds for providers who provide a disproportionate amount of indigent care. It is also not as likely to provide care to all county residents, whether they are documented or not. Moreover, even when parents have health insurance coverage through their work, they are often unable to afford the extra cost of covering their dependents under the same policy.

A major initiative of the 1997 Balanced Budget Act was the enactment of the Children's Health Insurance Program (CHIP), which permits states to increase the number of children eligible for health insurance either through expansion of Medicaid or through the development of a new program covering income levels above the Medicaid eligibility level. In response to this legislation, California has enacted the Healthy Families Program to expand health insurance coverage among children in the state's low-income families. Unfortunately, by September 1999 the total enrollment in Healthy Families and related programs in San Diego County was only 13,340—a fraction of the children estimated to be eligible.[5] The low participation in the program in many parts of California has been attributed to the fact that while many eligible children may have been born in the United States, and are thus citizens, their parents were concerned that signing up for such a program might be considered a form of public assistance. This would disqualify the parents from citizenship. In its early manifestations, the enrollment process for Healthy Families was also extremely cumbersome.

In May 1999 the Immigration and Naturalization Services (INS) issued proposed regulations identifying only three programs which would be *likely* to result in public charge determination—Temporary Assistance to Needy Families (TANF) cash benefits, Supplementary Security Income (SSI), and Medicaid for long-term institutionalization. According to the INS, participation in Medicaid for medical care and CHIP will not result in public charge determination.[6] However, it is unclear to what degree this clarification has been communicated to or accepted by San Diego's new immigrant populations. The passage and implementation of welfare reform has also led to increased concern about taking advantage of publicly funded health services and health insurance. As part of welfare reform, many women with children are moving into jobs that have no or unaffordable health insurance coverage. And while Medicaid may provide these women with transitional benefits, it will not do so for the long term.

2. Health Insurance Coverage in Tijuana

According to 1999 estimates, 564,858 persons in Tijuana have no public insurance coverage, 630,856 are covered by the *Instituto Mexicano de Seguro Social* (IMSS), 53,480 are covered by the ISSSTE (the insurance system for government workers), and 40,132 are covered by ISSSTECALI.[7] Data on those with no government coverage who have private insurance are not available, although nationally this number likely totals fewer than 2 percent of Mexicans. Persons with no health insurance coverage are generally dependent upon primary clinics run by the health department or upon private providers whom they pay out-of-pocket. The IMSS system is available to all permanent workers at maquiladoras and most other employees of companies in the formal sector.

The Mexican Social Security reforms of 1995, in addition to changing how retirement funds were credited to individual accounts, also changed the proportion of the IMSS medical costs paid by the employer, the employee, and the government. The government's share was increased significantly. These reforms also created two possibilities: that employers would be able to opt out of the IMSS by providing a comparable or better benefit package to their employees and that the IMSS could contract out services to private providers or networks of providers. For example, banks are currently outside the IMSS system and are able to contract for health coverage for their employees. The regulations spelling out this option for other industry sectors have not been issued and most observers believe that they will not be issued before 2001, when the next national administration in Mexico will take office. It is worth noting that Mexico has received a World Bank loan of approximately $700 million to modernize the IMSS and to acquire needed equipment and management capacity.

In the meantime, because of limited funding, many local enrollees in the IMSS complain that there are long delays in receiving health care services and also that much of the medical equipment used by service providers is not as modern as that found in San Diego. There is also some complaint that many of the better-trained physicians are not willing to work for IMSS wages, although a number of physicians are able to work part-time at the IMSS and part-time as consultants in their private practices. Because of Tijuana's proximity to San Diego, a number of Mexicans who can afford it go there for specialty care. There are many private physicians and hospitals in Tijuana that cater both to residents of Tijuana and to U.S. residents who are seeking less expensive and/or more culturally appropriate care.

3. Cross-Border Utilization of Services and Cross-Border Health Insurance Coverage

There is a great deal of movement across the border for health care services. Residents of Tijuana go to San Diego for specialty care, either because they have a relationship with a physician or clinic or because they happen to work there. Many persons pay for care out-of-pocket, some are entitled to U.S. health insurance by virtue of employment or entitlement (such as Medicare), and some have Mexican health insurance that pays for care in the United States within certain limits. Similarly, residents of San Diego County and other Southern California counties frequently go to Tijuana to receive medical care and to purchase medical products. Because dentistry and outpatient pharmaceuticals are not covered by Medicare, many retirees who live in the United States go to Tijuana for less expensive pharmaceuticals and dental care. And many persons

without insurance in the United States seek care in Tijuana because it costs less and/or because it is more culturally appropriate. A much-quoted study by San Diego Dialogue found that about 250,000 of the 6 million northbound border crossings a month during the summer of 1992 were either trips to Tijuana to access medical care or purchase pharmaceuticals or returns from such trips.[8]

Some employers in the United States cover care in Mexico as part of their benefits, both because they have some employees who live in Mexico and also because care is often less expensive there. In a survey of employers in 1995-96 on the Texas/Mexico border, researchers found that for some companies, conversion to a managed care arrangement resulted in less utilization of health care services in Mexico by their employees. Two factors seemed to contribute to this decline in utilization: primary care was now available for a low copay and deductible in the United States and the gatekeeper physician had to make the referral to care in Mexico.[9] The primary concern among Mexican physicians was that reimbursement was often not forthcoming from such arrangements from the insurance company in the United States. In San Diego a number of companies have provided health benefits for their employees who live in Mexico, as well as for their families. These benefits cover health care received from specified providers in Mexico and often do not cover care in the United States.

In response to concerns about the amount of protection offered by some of these arrangements, the California Legislature recently enacted Senate Bill 1658, which requires that health care service plans licensed in Mexico who sell coverage in California for care to be delivered in Mexico be subject to some of the provisions of the Knox-Keene Act, the legislation which regulates health care service plans in California. Some of these requirements include requiring that advertising, solicitation material and contracts be in compliance with the provisions of the act. Funds from subscribers must be deposited in a California bank and a substantial net equity is required on the part of the insurance provider. Furthermore, these plans are limited to selling employer-sponsored group plan contracts exclusively for the benefit of Mexican citizens legally employed in California and for the benefit of their dependents regardless of nationality. These plans pay for, reimburse the cost of, or arrange for the provision or delivery of health care services that are to be provided or delivered wholly in Mexico—with the exception of out-of-area emergency or specialty care.

The Knox-Keene Act, while bringing some protection to enrollees, fails to note, for instance, that a number of the persons who live in Mexico and work in the United States may be U.S. citizens. (San Diego Dialogue estimated that about 10,000 of the northbound commuters they identified in 1992 were actually U.S. citizens.) Also, these health care plans are often not licensed in Mexico. Authorities in Mexico are currently examining proposals for regulating managed care plans.

On the other hand, an HMO that is based in and licensed in California may be able to extend its service area to Mexico without any further permission from its regulator, the California Department of Corporations (DOC). Currently, however, at least one insurer that plans to cover services in Tijuana is seeking approval from the DOC. These HMOs may have to also become licensed in Mexico. Insurers in Mexico who also cover services in California for Mexican residents who work in Mexico do not have to obtain California licensure. Further discussion

between Mexican and California authorities might be warranted in order for appropriate protection of insureds to be combined with incentives to offer such coverage.

The Mexican government offers a program called *Seguro de Salud Para Familias* to Mexican citizens who work in the United States and have families in Mexico. For the payment of US $250-300 annually (depending in part on the strength of the peso) a worker or his employer in the United States can buy coverage under IMSS for the worker's family. The program was initially designed for migrant agricultural workers, who could purchase such coverage for their dependents at a Mexican consulate. Such a program may not be as applicable to persons who work in San Diego and who have a family in Tijuana to whom they return at least several times a week.

4. Development of Cross-Border Delivery Systems

There have been some attempts to develop primary care networks for U.S. retirees and others in Baja California in conjunction with emergency evacuation services to hospitals in San Diego. For persons living in Baja, it would seem preferable for many to be able to have primary care in Ensenada, Rosarito or Tijuana and specialty care in San Diego. At the same time, persons who have moved to San Diego may wish to receive primary care in San Diego from their long-time physicians who are based in Tijuana. In order for cross-border PPOs or cross-border HMOs to function effectively, it is important to have good communication and trust between physicians across the border and also between physicians, labs and hospitals in Mexico and in the United States. Telemedicine provides unique opportunities to provide increased cross-border coordination and collaboration in patient care. In principle, an HMO in San Diego or an insurance company in Mexico could provide coverage that was cost-effective and that incorporated the comparative advantages of both countries' medical care systems.

For persons with chronic disease or special health needs, it may often make sense to develop binational delivery systems for care. For example, San Diego Children's Hospital currently provides care to some Tijuana residents in need of its specialized services. Similarly, children who have hemophilia and live in Mexico regularly attend the camp organized by the Southern California Hemophilia Association.[10] The relatively lower cost of living and the availability of less expensive household help also means that many U.S. citizens with disabilities, who are living on a fixed income or stipend from Medicaid, can live more independently in Mexico.

Another area in which increased coordination is desperately required is in emergency medicine. Although there have been attempts to improve cooperation, ground ambulance transport across the border has faced many obstacles, including traffic congestion, poor communication between service providers, the unwillingness of drivers to drive ambulances on the other side of the border, delays by customs and immigration officials, and delays by hospital payment requirements. This situation is further exacerbated by the fact that U.S. auto insurance covering emergency vehicles is not valid in Mexico. All of these conditions contribute to less than optimum care for emergency patients.[11]

Health Care Coverage for Retirees in Mexico

There currently may be as many as 80,000 retirees in Tijuana, Rosarito and Ensenada who are eligible for Medicare. This number includes relatively affluent residents of retirement communities, persons of low to moderate income living in trailer parks and in the cities, U.S. citizens of Mexican origin, and Mexican citizens who worked long enough in the United States to be eligible for Social Security and Medicare if they were permanent residents of the United States. However, one gap in Medicare is that, except in very limited conditions, it does not cover care for services received abroad.

A further problem is that in order to remain eligible for services in the United States, residents in Baja must continue to pay their $45.50-a-month premium for Medicare Part B coverage, which includes physician care, outpatient diagnostic services and home health care. If they drop this coverage and later reinstate it, they must wait for an enrollment period; in addition, their monthly premium will increase by 10 percent for each year they were not enrolled after the age of 65.

Medicare medical savings accounts, which were approved in the 1997 Balanced Budget Act, are not available for persons who live abroad for more than 183 days per year. Although some Medigap insurance policies cover care abroad, it is generally just for emergencies that occur during the first 60 days of a trip out of the country. Medicaid, which covers most nursing home care and physician and hospital services for the indigent, also does not pay for services abroad.

Extension of Medicare and/or Medicaid coverage to those living in Baja California could save the United States government money for a number of reasons. First, the care is likely to be significantly less expensive, especially for primary care. For San Diego residents in particular, coverage of health care services in Baja California would likely replace more expensive care in San Diego. Second, the availability of this coverage would encourage more persons to retire to Baja California, where they would replace a great deal of care they would have obtained in the United States with less expensive care in Mexico. Finally, many individuals could retire to Mexico and remain independent with the use of household help whom they would not have been able to afford in the United States. Note that if these persons remain in the United States they are likely to require a great deal more public support (e.g., they would have to become medically indigent in order to be cared for in a nursing home paid by Medicaid).

One of the principal constraints on developing major retirement communities in Baja California, particularly south of Ensenada, is the lack of high-quality, affordable and proximate medical facilities. With at least partial Medicare coverage, it might be possible to develop such facilities. Given the attractiveness of the area, the climate and the proximity to San Diego and Southern California, one suspects that such communities could soon attract billions of dollars in investment and perhaps generate hundreds of millions of dollars in annual expenditures in Baja California.

One option to test the impact of making Medicare portable for retirees in Baja California would be to apply for a research and demonstration waiver from the Health Care Financing Administration (HCFA), which would provide this coverage to a randomly selected group of retirees in Baja and compare their service utilization and costs to a control group with similar

characteristics but without this benefit. Some possible alternatives would be to provide just a portion of Medicare's package of services in Mexico, to reimburse for services in Mexico at local prices, or to contract with a cross-border HMO for all Medicare benefits at a discounted price. There would be a number of challenges in administering the program, assuring quality of care, and developing a credible evaluation protocol.

Other possibilities would be to conduct an experiment permitting Medicare medical savings accounts to be purchased by retirees in Mexico and possibly even permitting some home- and community-based reimbursement for long-term-care services under Medicaid. In order for HCFA to initiate such a research and demonstration waiver, the U.S. Congress would probably have to initiate it and approve the necessary expenditure of funds.[12]

Policy-makers considering innovations to expand health care coverage to U.S. retirees in Baja California should carefully consider the consequences of their actions. On the one hand, increasing Medicare portability could serve to expand the private health care sector in Baja California, opening up additional avenues for access to care for the uninsured segments of Tijuana's population. A strong private health care sector would also increase pressure for the devolution of IMSS to private providers. On the other hand, an expansion of the private system that was fueled primarily by providing care to U.S. citizens in Baja who might otherwise seek care in San Diego could serve to increase the price of health care services. These alternatives deserve careful study before large-scale actions are taken by either Mexican or U.S. health authorities.

The NAFTA and Potential Cooperation in the Delivery of Medical Care and Medical Education

Although the North American Free Trade Agreement (NAFTA) mandates free trade in most goods and services, much of the health services industry is exempt from its requirements in one way or another. For instance, open contracting by Mexican providers for Medicare patients and by U.S. managed care companies for some IMSS management and contracting services are not required because government-funded health and welfare programs were exempted from the provisions of the NAFTA. But this does not mean that such contracting might not be beneficial.

In another exception, states were permitted to enter stipulations in the annexes to the NAFTA to continue regulatory practices that had existed at the time of its passage. This is how states have been permitted to continue to discriminate against graduates of non-U.S. or non-Canadian medical schools in terms of licensure. Prior to NAFTA, Mexico had generally required that doctors be Mexican citizens in order to receive a *cedula*, which would permit them to practice medicine in Mexico. After NAFTA, Mexico has said that it will work on reciprocity arrangements with nations that permit Mexican-licensed physicians to practice within their borders.

NAFTA does require the parties to demonstrate that physician licensure requirements are based on objective and transparent criteria and that they not be more burdensome than necessary to ensure the quality of a service. The agreement also states: "The parties shall encourage the relevant bodies in their respective territories to develop mutually acceptable criteria for licensing

and certification of professional service providers and to provide recommendations on mutual licensure…" Since licensure of physicians is a state issue in the United States, California could possibly set criteria for licensure or limited licensure of Mexican physicians in the United States, and Mexico could, in principle, provide some reciprocity to California physicians who wanted a limited practice in Mexico. At the same time, it must be understood that there is a far greater variation between medical schools and training in Mexico than there is in the United States, and that it is unlikely that blanket reciprocity would be granted prior to the development of a uniform, reliable licensing exam in Mexico. The General Agreement on Trade in Services (GATS) to which both countries are signatory also seeks to promote transparency in licensure qualifications. One area that might be worthy of exploration would be certification to provide services through telemedicine in both directions.

Finally, although NAFTA requires free trade in goods, it does provide an exception for national and state product standards at levels each considers appropriate for safety, health, the environment or consumer protection. This is why pharmaceuticals generally cannot legally be imported and resold. It might make sense to establish which pharmaceuticals in Tijuana are essentially equivalent to U.S. brands and which might pose a threat. There have been difficulties with unlicensed pharmacies in the United States providing pharmaceuticals to recent immigrants who cannot afford U.S. prices. A number of elderly persons go to Mexico for all their pharmaceuticals since they cannot afford the prices in the United States. The price variation is due primarily to the fact that pharmaceutical prices are regulated in Mexico, while they are not in the United States. Several studies have indicated that pharmaceutical prices in Mexico are generally half to two-thirds U.S. prices. Some reliable information for consumers as to which drugs are safe and appropriate to buy in Mexico and which are not would be helpful without impinging upon their freedom to choose to buy pharmaceuticals in Mexico.

Each of these areas might profitably lead to much more cooperative activity. As sketched out above, several high-quality binational delivery systems could be developed with physicians and hospitals affiliated on both sides and a concerted effort made to practice medicine cooperatively. Each system would offer services that incorporated their strengths in terms of location, language, specialized services, and cost. In-service training could take place within these delivery systems and the systems could contract with employers, insurance companies and government programs. Telemedicine and the Internet would make such collaboration more feasible and productive.

Similarly, medical schools and teaching hospitals on the California side of the border could develop far more comprehensive relationships with comparable institutions in Tijuana and Baja California in general. Continuing medical education, exchange of residents and rotation of medical students to the other country all take place to a limited extent currently, but there is far more scope for experimenting with much deeper and broader collaboration in medical education, research and treatment. The United States will desperately need well-trained clinicians who are culturally sensitive and linguistically capable to treat its growing Mexican-origin population. Similarly, Mexico could benefit from several flagship medical schools that have access to the most advanced equipment, a variety of training locations, well-funded biomedical research and a unique ability to offer binational training and credentials that are world class. With enhanced collaboration, both San Diego and Tijuana could become destinations for medical consumers

from both the United States and western Mexico and also provide first-class service to local residents who need medical care.

Concluding Thoughts and Recommendations

The creation of joint strategies for promoting health in the cross-border region will require new systems of assessment and evaluation in order to help the San Diego/Tijuana region define its position and benchmark progress toward mutually recognized health care objectives. A set of cross-border indicators for health care would be one step toward monitoring progress to build a healthier San Diego/Tijuana region. In addition, promoting health care on a binational basis will require a greater sense of transparency and accountability on the part of state and local agencies. As responsibility for health care, particularly the provision of public health services, is devolved (and perhaps privatized) on both sides of the border, regional stakeholders must have the ability to gauge performance against objectives and see across the various "stovepipes" of service delivery.

As summarized throughout this briefing paper, the following efforts could serve to strengthen health care in the cross-border region:

- The binational region should develop a coordinated effort to achieve a sufficient immunization rate so that spread would be difficult for most immunizable diseases ("herd immunity").

- Relevant authorities in San Diego/Tijuana should pursue joint initiatives to ensure world-class standards for the quality of laboratory testing on both sides of the border.

- San Diego County's efforts to enroll its low-income uninsured children in the Healthy Families program should be evaluated in light of the recent INS regulations on the effect of participation in these programs on naturalization processes. At the same time, the INS should be challenged to offer further clarifications regarding the propensity of participation in these programs to impact individual efforts towards naturalization.

- Higher levels of cooperation in the provision of emergency medicine should be pursued as a top regional priority. The recent case of Donald Kraft highlighted the importance of this issue to stakeholders on both sides of the border.

- Policy research should be conducted to confirm whether an HMO based and licensed in California could extend its service area to Mexico without formal permission from the California Department of Corporations. Research should also be conducted to examine how California might set criteria for licensure of Mexican physicians to practice in the state. This research would also pursue whether the Mexican federal government could, through reciprocal measures, permit California physicians to develop a limited practice in Baja California.

- Telemedicine strategies should be pursued to link physicians, labs and hospitals across the border. Feasibility studies should be initiated to map the region's existing telemedicine

infrastructure and explore the requirements for expanding local telemedicine capacity.

- A pilot project to test the value of making Medicare portable for retirees in Baja California should be developed through a research and demonstration waiver from the Health Care Financing Administration.

- A neutral cross-border collaborative effort should be establish to provide information to the public regarding which pharmaceutical drugs are safe and appropriate to purchase in northern Baja California.

- Broader collaboration should be pursued between medical institutions on both sides of the border around medical education, research, training and treatment. The Cross-Border Health Education and Leadership Network, a joint project of *Universidad Autónoma de Baja California* (UABC) and the University of California San Diego's Division of Extended Studies and Public Programs, is a strong foundation for building more regular leadership development and training programs for medical professions on a binational basis.

- A formal process should be established to explore the viability of developing major retirement communities on the Pacific Baja California coast as a sustainable economic development strategy. Such a process would evaluate market demand for such facilities, explore the legal and financial challenges for developing these communities and the medical care infrastructure to support them, and establish strict criteria for ensuring the protection and preservation of wildlife habitats and other critical natural resources.

One of the great challenges in the next decade will be the integration of Mexico with the rest of North America and all that implies. San Diego and Tijuana are at once feeling the effects of this integration and are on its leading edge. San Diego and Tijuana are unique on the border, and they have a unique opportunity to develop binational capacity to train medical practitioners, design and operate a binational public health system, and create a context in which truly binational medical outreach, finance and service delivery can develop. The degree to which they meet these challenges will determine in part the nature of the metropolitan area they are able to create.

About the Author

David C. Warner is the Wilbur Cohen Professor of Public Affairs at the Lyndon B. Johnson School of Public Affairs at The University of Texas at Austin. He has a BA degree from Princeton University, an MPA and Ph.D. in economics from Syracuse University, and did post-doctoral study at Yale University. He has taught at Wayne State University, Yale University and the University of Texas. Since 1983 he has also been a visiting Professor at the University of Texas School of Public Health at Houston's San Antonio campus. His publications relating to border health issues include policy research projects he has directed at the LBJ School, including: *The Health of Mexican Americans in South Texas* (1979), *Maternal and Child Health on the U.S.-Mexico Border* (1988), *Health Care Across the Border* (1993), *NAFTA and Trade in Medical Services* (1997), and *Getting What You Paid For* (1999). He has also written articles on this subject for the Journal of the American Medical Association, the Journal of Border Health, and the Commission for the Study of International Migration and Cooperative Economic Development. He served on the Institute of Medicine's advisory committee on border health during 1994 and 1995.

Notes

[1] 1999 population estimated for San Diego in State of California, Department of Finance, "County Population Projections with Race/Ethnic Detail." Sacramento, California, December 1998 downloaded from http://www.dof.ca.gov/html/Demograp/Proj_race.htm; Tijuana estimated 1999 population from Tijuana Today downloaded from http://www.tijuana.gob.mx/humano2.html.

[2] Ensenada, Rosarito, Tecate, and Mexicali population estimates are for 1995 and were downloaded from http://www.bajaplaza.com.mx/bajacalf/estad/bc_pob.htm. The estimates for 1999 for Orange, Riverside, and Los Angeles Counties are from State of California, Department of Finance, "County Population Projections with Race/Ethnic Detail." Sacramento, California, December 1998 as accessed in note 1 above.

[3] Wulsin, Lucien, Sepi Djavaheri, Jan Frates and Ari Shofet. "Clinics, Counties and the Uninsured: A Study of Six California Urban Counties." February 1999.

[4] Wulsin, Lucien, Sepi Djavaheri, Jan Frates, and Ari Shofet. "Clinics, Counties and the Uninsured in California: Focus on San Diego." A summary of their analysis, Council of Community Clinics, San Diego, 5 March 1999.

[5] Enrollment figures provided by the County of San Diego Department of Health and Human Services. See also Managed Risk Medical Insurance Board Home Page, http://www.mrmib.ca.gov/MRMIB/HFP/HFPRpt 1.html

[6] Federal Register, Vol. 64, No. 101, 26 May 1999, pp. 28675-28688.

[7] *Instituto de Servicios de Salud Pública del Estado de Baja California, "Distribución de la Población por Institución y Juridicción para 1999."*

[8] San Diego Dialogue. "Who Crosses the Border." 1994, p. 2.

[9] Albro, Katherine and Kindra Norton. "Cross Border Collaboration in Medical Practice." Chapter 6 in David C. Warner, Project Director, *NAFTA and Trade in Medical Services Between the US and Mexico*, Report No. 7, U.S.-Mexican Policy Studies Program, Lyndon B. Johnson School of Public Affairs, The University of Texas, Austin, 1997.

[10] See for instance the conference synopsis, "Managing Chronic Illness Along the U.S./Mexico Border: Hemophilia as a Model," November 20-22, 1998, El Paso Texas. Sponsored by the University of Texas-Houston Medical School and the Gulf States Hemophilia Center.

[11] Albro and Norton. p. 236.

[12] David C. Warner, Project Director, *Getting What You Paid For: Medicare Coverage for Retirees in Mexico*, Lyndon B. Johnson School of Public Affairs, The University of Texas at Austin, 1999. Also see David C. Warner, "Toward Better Access to Health Insurance Coverage for U.S. Retirees in Mexico," Cross Border Health Insurance Initiative, Issue Paper Topic No. 4, June 1999.

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