# COMMUNITY AND ECONOMIC DEVELOPMENT IN HEALTH CARE: THE U.S.-MEXICO BORDER CASE*

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## ABSTRACT***

*Health economics is the study of how society distributes scarce resources along the U.S.-Mexico border to provide health care. Just how do we divide up our resources for its population's health care. Just how do we divide up our it better? Five basic health economics issues affect the borderlands: (1) uneven economic development, (2) U.S. national economic issues that affect health care, (3) effects of the North American Free Trade Agreement (NAFTA), (4) lack of infrastructure to support environmental policies and (5) lack of funding for basic services.*

*The urban centers along the border show economic development commensurate with other American cities. However, a substantial number of urban border dwellers lack the stable employment and insurance necessary for adequate health care. Vast rural areas along the border remain mired in poverty and are typically underserved by health providers. Cross border utilization of health services is a part of this border culture.*

*Federal interest in budget deficit reduction and cuts in public health programs such as Medicare and Medicaid do not bode well for the social infrastructure projects needed at the border. Reform toward "managed care" will increasingly disenfranchise the rural and poor along the border, since its "market directed" and "profit oriented" nature will best serve urban affluent groups.*

*Although NAFTA implies increased trade and human interaction, little mention is made regarding health in the two thousand-paged document. NAFTA has resulted in an acceleration of the "maquila" phenomenon, with associated northward migration and transborder migration. Economic development on the south side of the border to respond to this migration and growth will undoubtedly stress U.S. health care providers, particularly public providers, given the shift toward managed care. Large increases in transborder health care utilization are also implied. The border's culture of routinely crossing to engage in commerce will easily extend to the market for health care.*

*Although Presidents Bush and Salinas agreed to pursue an integrated border environmental plan in 1990, the border is still severely underfunded in terms of environmental infrastructure. The maquiladora phenomenon has produced substantial toxic waste and growing colonias experience crowded, unsanitary living conditions. Community involvement and leadership is the answer to increased government support and infrastructure.*

*Finally, funding for basic health care services along the border is directly dependent on the tax base, which falls with lower incomes as one approaches the border. One solution is to expand tax bases to larger entities, like counties, states and the federal government, although the mood in Washington is anti-tax and anti-expenditure.*

*Generally, the shared border experience unites the populations along its length so that problems of economic development and the provision of health care can be approached as problems specific to the region, requiring unique regional solutions. Lay health workers, mobile clinics, telemedicine and community mobilization have all proven effective in various border regions. If the U.S. economy continues to grow and if the maquiladora phenomenon matures, it is likely that more workers will access primary care via their workplaces. And again, indigenous leadership and economic development are the main engines to mobilize a unified community to support basic health services.*

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## INTRODUCTION

The standard textbook definition of economics is: "The study of the allocation of scarce resources." Economists study how societies choose to divide up finite resources among what appear to be limitless desires. The health or medical economist studies issues that relate to just how society divides up those scarce resources to provide health care for its population. Hence, we ask the multifaceted question, "Just how do we divide up our scarce resources along the U.S.-Mexico border to provide health care, what is the outcome of that practice, and how might we do it better?" This brief essay will provide an overview of the links between health economics and economic development along the border, through the eyes of a medical economist.

The format for this discussion will center on five major "health economics" issues that affect the borderlands.

1. Uneven economic development
2. U.S. national economic issues that affect health care
3. Effects of the North American Free Trade Agreement
4. Lack of infrastructure to support environmental policies
5. Lack of funding for basic services

These five issue areas are discussed as they affect the themes listed in the University of Arizona, Rural Health Office's "Border Vision Fronteriza" project. This is a federally funded program to develop U.S.-Mexico Border Health Collaborative Outreach Demonstration Projects.

## MAJOR HEALTH ECONOMICS ISSUES ON THE BORDER

### *Unequal Economic Development*

Global studies in economic development have documented the obvious link between economic achievement and health. The first thousand dollars in disposable income makes a huge difference in the health profile of any developing country as infant mortality, perinatal and neonatal death rates fall, and longevity rates rise *(1)*. What is not so clear, however, is which comes first. Can health care interventions, making a healthier and therefore more productive population, act as a catalyst for economic growth? Or is it the other way around as random successes economically pave the way for a healthier population? In the literature of economic development, this continues as an unsettled debate *(2)*.

What is clear with regard to the border is that affluent populations tend to have better health care and to be healthier in general, and poor populations exhibit the health profiles typical of those found in the developing world *(3,4)*. This dichotomy in health care is readily apparent along the border on both sides in a comparison of urban versus rural areas.

From Brownsville, Texas on its eastern end, the U.S.-Mexico border winds its way along nearly 2000 miles to reach its western terminus at the Pacific Coast in the Tijuana/San Diego metroplex. The urban areas along its route show economic development commensurate with other American cities. What remains are vast, rural borderlands, mired in poverty and typically underserved by any health care providers.

The urban border centers provide health care via the damaged reforms now sweeping the U.S. *(5)*. Care is essentially provisional and depends on stable incomes with health insurance. A substantial portion of urban dwellers all along the border lack both stable employment and health insurance. They avail themselves of emergency room service at local hospitals and clinics provided by public health service organizations, or are otherwise underserved.

These underserved and predominantly Hispanic populations, along with aging retirees and rural poor, constitute a growing clientele for cross border utilization of health services *(6)*. Earlier samples of such utilization revealed mostly disadvantaged economic participants from the U.S. Recently, studies have shown a dramatic increase in the numbers of insurance covered and affluent individuals seeking care in Mexico as an alternative to the high cost U.S. health care system *(7)*. Indeed several corporate entities have begun offering their employees financial incentives to seek company insured primary care in Mexico.

Among Hispanic health care consumer groups, seeking care in Mexico is in line with a border cultural tradition that places more emphasis on form and dignity than is common in the U.S. health care system *(2)*. Often criticized for catering to the convenience of providers, the U.S. system is often seen as foreign and harsh by those grown accustomed to a sense of dignity normally found between doctor and patient in Latin America. A border culture that allows residents on both sides to access health care of their choice should come as no surprise to anyone familiar with the border phenomenon. Health care is but one of many items routinely preferred in cross border commerce.

Mexican per capita income is approximately one tenth that of the U.S. *(2,8)*. With that degree of economic disparity, one should expect vast amounts of legal and illegal migration as economic pressures mount in a crisis prone Mexican economy. Add to this the effects of a national "leveling" of incomes in the U.S. For the first time in this nation's history, the statistical odds that new labor force entrants will do economically better than their parents are merely even. This sobering realization on the part of working class individuals has lead to a more determined effort to be economically rational in terms of cross border expenditures. Thus we see an increase in transborder utilization of health care from all income levels *(2,6,7)*.

## U.S. NATIONAL ECONOMIC ISSUES

There are several national economic issues that directly affect health care along the U.S.-Mexico border. The first is a preoccupation with the size and makeup of federal expenditures. The second is the frenzy of de facto health care reform taking place in the aftermath of the failed Clinton health reforms *(5,8,9)*.

### *Debt and Deficit*

The federal deficit in 1996 was projected to fall in the neighborhood of $180 billion *(8)*. The accumulation of such deficits over the years constitutes the national debt. Its total now exceeds $5 trillion. While earlier years have seen much consternation over the governmental habit of deficit spending, not much was done to change the pattern. That may well be changing with the mood in Washington among both Democrats and Republicans. There may well now be the will to balance the budget. That can be done in one of two ways. One, raise taxes to match the expenditure patterns of government. Included in those expenditures might be direct funding for provision of primary care along the border, environmental infrastructure to reduce the hazards of unclean water, immunize at risk populations, and to provide transportation and housing.

The second method, and the method of choice for the current Congress, is to pare down expenditures rather dramatically to match a reduced tax revenue flow after various tax breaks have been enacted. This choice does not bode well for social infrastructure projects like those necessary along the border.

In the past there were two major sources of expenditures that remained immune from budget cuts. They were Pentagon expenditures and those of combined health care programs including Medicare, Medicaid, Veterans health care, etc. Today, after four years of smaller Pentagon budgets, there is rising support in the Congress for a military capable of sustaining "two theater wars" and one "regional conflict" at the same time. Thus the main target for budget cuts becomes the nation's commitment to health care *(8)*.

For the border, this implies that federal funds for most health care initiatives as well as economic development schemes will diminish and those projects will have to be state and locally funded. The will to do so has to come from committed community leaders who can mobilize local and state support. While self rule and local bonding capacity for border infrastructure projects cannot solve all the problems, it would begin the process whose completion would have to wait for a return of the Federal Government to its commitment to the health of its citizens.

### *De Facto Health Care Reform*

With the failure of the Clinton health care reforms has come a wave of frenzied changes in the private health care sector *(9)*. The operative phrase is "managed care" as the system recreates itself into a caricature of that envisioned by President Clinton. Fee-for-service and indemnity health insurance are being replaced by care given to large groups, "managed" by insurance providers. Physicians are encouraged to defensively join large group providers and the distinction between insurer and provider are blurred as health maintenance organizations take on the dual roles as both. Hospital chains are buying insurance companies, and vice versa, and most recently, doctors feeling squeezed by patients and insurers are deciding to buy the insurers for whom they previously worked *(5)*.

What this means for the border is that urban groups must adapt to the structure that eventually appears from all this change. Low income populations are not well served by the reforms since they are primarily "market directed." This is a metaphor for "profit oriented" and, since the inception of prospective payment, there is little profit in the care of the poor. Affluent urban groups along the border will be well served, the poor will not. Given the vast expanses of rural territory along the border with incomes substantially below the national average, the overall picture of the state of health care after reform fever has settled, is one of a reduced level.

## EFFECTS OF THE NORTH AMERICAN FREE TRADE AGREEMENT

The European Economic Community has been actively engaged in debate over the form and substance of its union for the past thirty years. It is a far from harmonious debate that is not yet settled. The U.S. and Mexico embarked on the same path and agreed to do so with "fast track" authority for the U.S. President. This allowed the U.S. President to negotiate an agreement in a mere eighteen months and then to ask Congress to vote simply, yes or no on its completed form.

In all two thousand pages of the agreement, little is mentioned of the health aspects of opening up the border for increased trade and human interaction. Compare this with the seemingly endless discussions in which the Europeans engaged trying to set standards for cross border credentialing of health care providers, international standards of weights and measures pertaining to health care, the quality standards for transborder shipments of human tissue and even standards for reimbursement for services of providers--to name just a few.

The immediate effects of NAFTA have been to accelerate the *"maquiladora"* phenomenon *(10)*. Eventually, foreign owned plants will proliferate throughout most of Mexico, but for the time being, the shortage of infrastructure there will keep most of the activity near the border. This means an increase in northward migration as Mexican citizens seek work in *maquiladoras*. This also means an ominous increase in the incidence of populations on

the south side of the border overwhelming Mexican governments ability to provide social infrastructure in border cities *(2,11)*. The net result has already been disease vectors whose origins are found in crowded living conditions without benefit of clean water and human waste systems. Transborder migration has increased, and analysts expect it to continue that trend *(12,13)*. Thus economic development on the south side of the border can lead to greater pressure on U.S. health care providers. Given the rush to managed care with its commitment to profitability and subsequent disregard for the poor, this implies larger populations served by public health entities on the U.S. side.

It also implies the possibility of large increases in transborder utilization of medical services *(2,6)*. Free trade means just that. Whoever can offer services at reasonable prices can expect to gain customers. Providers are reasonably well trained in Mexico and labor costs are a fraction of those in the U.S. Pharmaceuticals sell at roughly one fifth the U.S. cost and ancillary services for dentistry, eyeglasses, home health care, care for the elderly and even specialty care for some types of rehabilitation are appearing with attractive prices on the Mexican side of the border. The border's culture of routinely crossing to engage in commerce will easily extend to the market for health care. NAFTA has facilitated such practices in a general sense even though the difficult European style negotiations have yet to be attempted *(10)*.

## LACK OF INFRASTRUCTURE TO SUPPORT ENVIRONMENTAL POLICIES

Presidents Bush and Salinas met in Monterrey, Mexico, on November 27, 1990. On that day they agreed to pursue an integrated border environmental plan that would address the rapidly changing environmental conditions found along the border. The agreement empowered the U.S. Environmental Protection Agency and its sister agency in Mexico to produce such an "integrated plan," to identify the problems, and delineate pathways toward solutions.

Specifically the EPA is charged with responsibilities to deal with pollution abatement for air and water, water supply problems, solid and toxic waste management, emergency preparedness, pesticides control, and toxic chemical regulation.

The picture of the border today is one of underfunding most aspects of environmental infrastructure that would allow effective control of a degraded environment. A complete list of the problems is not possible here, but a few examples should suffice.

The *maquiladora* phenomenon has produced substantial amounts of toxic wastes, the disposal of which appears questionable at best. Rivers that run through Mexican border areas and then into the U.S. are among the most polluted in the world. Witness the Santa Cruz in Nogales and the New River in Mexicali. National origins of the toxins are difficult to trace since many come from foreign owned *maquiladoras* on the Mexican side.

Substandard housing developments called *"colonias"* are found in Texas and New Mexico. These have high incidence rates of hepatitis caused by fecal contamination of drinking water. Dust pollutants and transportation problems caused by lack of sufficient roadways are endemic with the net result being that thousands of children are at risk as their health is imperiled. As one public health official put it, "our most important task is to insure that children are served...that the relationship of children to health, education, housing and basic services is strengthened so that children are successful." Such a commitment is difficult to achieve in the dusty colonias of Texas and New Mexico.

The only recent successes in *colonia* remediation have stemmed from intense community involvement and leadership. This involved a mobilization of affected communities to lobby state and local entities for funding for clean water systems and to inform colonia populations regarding preventive measures in health care. It is interesting that Arizona and California have substantially fewer problems of this kind due to more active state governmental regulations regarding real estate development. Thus preventive activism at the governmental level is one path, while remediation of existing *colonia* problems is another.

## LACK OF FUNDING FOR BASIC SERVICES

Funding for basic health care services along the border is directly dependent on the tax bases in border states and counties. National comparisons reveal those tax bases to be limited as incomes generally fall as one approaches the border *(2)*. Furthermore, local tax payers tend to be exclusive about which services they will provide for whom *(14)*. The *colonia* case is a good example. Most of them exist outside incorporated municipalities. Taxing themselves to provide water and sewer services for colonia residents outside their taxing district is not something most city residents are likely to do.

The computational reasoning behind the denial of basic service expenditures is straight forward. If property values or area resident's incomes and purchasing habits provide more municipal revenues than it costs to provide services then, of course, services are provided. If not, then don't provide them.

The developmental signature of most of the rural borderlands though is one of poverty and low property values. Thus it is not likely that those residents own local tax base will ever be able to support the provision of basic services and infrastructure.

Border populations in general already pay more in taxes per thousand dollars in

income than most other populations. They are poor and therefore save less than affluent populations. This means they pay a higher percentage of their incomes through regressive sales taxation as they consume rather than save their incomes.

The only gambit left is to expand the tax base by including larger taxing entities. Border municipalities turn from cities to counties, to state governments for help. The Federal Government is the "tax base of last resort" but, as already discussed, the mood in Washington is decidedly anti-tax and anti-public expenditure.

Past strategies by local, county, and state agencies in denying basic service funding have opened the door eventually for federal funding. However, this strategy is inherently too risky in the current fiscal atmosphere. There is no doubt that lower level taxing entities will have to shoulder a larger share of the burden as the federal level grapples with issues relating to the debt and the yearly deficit. Indigenous leadership and economic development are the main engines to mobilize a unified community effort to support basic health services.

## HEALTH ECONOMICS ISSUES AND THE "THEMES"

The culture of the border is pervasive in discussions of all five economic issues. Common language, customs and family relationships unite populations across the border. Commerce, including that in medical care flourishes in both legal and illegal ways.

Passage of the North American Free Trade Agreement merely institutionalized the close relationship that already existed between the U.S. and Mexican economies. To be sure, some "cultural clashes" are inevitable. Witness the differences in contract etiquette, business methods, and legal remedies apparent in the two systems. Witness also the differences between fast paced clinical practices in health maintenance organizations in the U.S. versus the "hands on" slower pace of Latin American medical care with its reliance on patterns of form and ceremony between provider and patient.

Generally, the shared border experience unites the populations along its length so that problems of economic development and the provision of health care can be approached as problems specific to the region, requiring unique regional solutions. The responses of this "culture of the border" to the four models of community outreach illustrates the point. Lay health workers or *"promotores"* have been successful in the urban areas of Texas where vestiges of a male dominant hispanic attitude previously stymied efforts to improve women's health. Mobile clinics have been successful in rural areas that can be specifically defined and scheduled so that those medically underserved areas have some access to primary care. The *colonias* of Texas and New Mexico have been particularly fertile ground for scheduled mobile clinics.

Telemedicine is still in its infancy as the technology matures. Downlink sites are becoming cheaper and more numerous along the border. This allows border clinicians more flexibility in choosing which subspecialties they need not offer on site due to access to them via telecommunications.

Community mobilization has proven its uniquely "border character" on many occasions from support of immunization in South Texas, to rallying support for infrastructure projects in the *colonias*, to forcing state and federal level responses to river pollution along the Rio Grande, Santa Cruz, Colorado and New Rivers. In each case indigenous leaders arose to mobilize the communities via religious organizations or other non-governmental organizations formed at the grass roots level. Without these organizations and these leaders, most of the border economic development and its subsequent positive effects on border health would not exist.

## CONCLUSION

Under the very best of conditions during the next 25 years, the North American Free Trade Agreement will help to economically develop Mexico and create a rising middle class there. Until then, the increased trade with its rising cross border traffic in humans and goods will strain the social services infrastructure on both sides of the border. With that as the expected short run scenario, current national U.S. economic priorities mitigate against expecting this nation to spend much on that infrastructure. That leaves primary expenditures on the infrastructures for clean water and sewer systems, adequate roadways, flood control, and toxic substance abatement lacking.

The frenzied move toward managed care sweeping across this nation will leave most of the poor along the border without contractual access to health services. The net result will be to put ever more pressure on public health offices to provide that care.

It is not likely that tax bases in the rural areas of the border will ever reach sufficient levels to support needed infrastructure and provision of primary care. These are areas whose main hope lies in some type of remote provision of care such as mobile clinics or telemedicine.

Against this dismal health economic backdrop stand the few rays of hope. Without federal help, communities can mobilize via efforts of their own leaders. Gradually local and state bonding capacities can be increased to provide access to capital markets for smaller scale infrastructure projects. Increased cross border utilization of health services is essential and moreover rational under the spirit of NAFTA. Wherever health care can be found most efficiently produced, either in

the U.S. or Mexico, border public health authorities can play a pivotal role in the education of those populations to become more sovereign as health care consumers.

As the *maquiladora* phenomenon matures, there is some evidence that such organizations are more frequently including worker primary care as a workplace necessity. There is less evidence that the industry as a whole will move to control the post-production distribution of toxic substances. Collaboration between public health authorities on both sides of the border and citizen leadership is essential to make the case for good corporate citizenship in the border environment.

Lastly, if the U.S. economy continues its slow growth and new jobs continue to be created, more workers will find access to care through workplace managed care programs. Ultimately that is the hope held high by the prospect of economic development. We return to the notion contained in the beginning of this essay with community economic development will come a strengthening of the population's health profile.

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# DESARROLLO ECONOMICO Y COMUNITARIO EN LA ATENCION MEDICA: EL CASO DE LA FRONTERA E.U.-MEXICO*

*Dr. Michael G. Ellis***

## RESUMEN

*La economía de la salud es el estudio de cómo la sociedad distribuye los recursos en el cuidado de la salud de su población. Simplemente, ¿Cómo dividimos los escasos recursos a lo largo de la frontera para proveer los servicios de salud?, ¿cuáles son los resultados de esa práctica y cómo pudiéramos mejorarlos? Existen cinco aspectos básicos que afectan la economía de la salud en la frontera: 1) Desarrollo económico desigual, 2) Cuestiones de la economía nacional de los Estados Unidos que afectan los servicios de salud, 3) Los efectos del Tratado de Libre Comercio (TLC), 4) Falta de una infraestructura que apoye a las políticas ambientales y 5) Insuficiente financiamiento de servicios básicos.*

*Los centros urbanos a lo largo de la frontera muestran un crecimiento económico comparable con el de otras ciudades americanas, sin embargo, un número significante de habitantes fronterizos urbanos carecen de un empleo estable y del seguro médico necesarios para una atención médica adecuada. Amplias áreas rurales de la frontera permanecen en la pobreza y están tradicionalmente subatendidas por los prestadores de servicios de salud. El uso trasfronterizo de los servicios de salud es parte de la cultura en la frontera.*

*El interés federal por reducir el déficit presupuestario y los recortes en programas de salud pública como Medicare y Medicaid no son un buen presagio para los proyectos de infraestructura social que se necesitan en la frontera. La reforma hacia la "atención administrada" incrementará la marginación de las áreas pobres y rurales de la frontera, ya que su naturaleza de "orientación al mercado" y "sus fines de lucro" se verá más beneficiada con los grupos urbanos pudientes.*

*Aunque el TLC implica mayor intercambio e interacción humana, poco se menciona sobre salud en el documento de dos mil páginas. El TLC ha resultado en una aceleración del fenómeno de la "maquiladora", con la inherente migración hacia el norte y transfronteriza. El desarrollo económico del lado sur de la frontera para poder responder a la migración y al crecimiento presionará, sin duda, a los prestadores de servicios de salud, particularmente a los servidores públicos, dado el cambio hacia la "atención administrada". Al igual, grandes incrementos en el uso transfronterizo de los servicios de salud se verán implicados. La cultura fronteriza de cruzar rutinariamente la frontera para hacer compras se extenderá fácilmente al mercado de los servicios de salud.*

*Aun cuando en 1990 los Presidentes Bush y Salinas acordaron seguir un plan integral ambiental fronterizo, la frontera continúa severamente subfinanciada en términos de infraestructura ambiental. El fenómeno de la maquiladora ha producido significantes cantidades de desechos tóxicos y las "colonias" experimentan condiciones de vida sobrepobladas e insalubres. La participación comunitaria y el liderazgo son la respuesta para lograr un mayor apoyo del gobierno y para mejorar la infraestructura.*

*Finalmente, el financiamiento de los servicios de salud básicos a lo largo de la frontera depende directamente de los impuestos, los cuales disminuyen proporcionalmente a los bajos ingresos conforme se aproximan a la frontera. Una solución es transpasar las tasas de impuestos a entidades más grandes, como los condados (municipios), estados y el gobierno federal, aunque la tendencia en Washington es anti-impuestos y anti-gasto.*

*Generalmente, la experiencia compartida en la frontera une a los pueblos a lo largo de esta, de tal manera que los problemas relacionados con el desarrollo económico y la prestación de servicios de salud pueden ser tratados como problemas específicos de esa región, los que requieren soluciones regionales específicas. Los promotores de salud, las clínicas móviles, la telemedicina y la movilización comunitaria han probado ser efectivas en varias regiones fronterizas. Si la economía de los E.U. continúa creciendo y si el fenómeno de la maquiladora madura, es posible que más obreros tengan acceso al cuidado de salud primario por medio de sus trabajos. Y de nuevo, el liderazgo local y el desarrollo económico son los motores para movilizar una comunidad unida para el apoyo de los servicios de salud básicos.*

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