BORDER HEALTH

Prepared for The California Wellness Foundation

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1. Importance/Urgency of the Issue

In its mission statement, The California Wellness Foundation has boldly announced its desire to fund research and projects that will have an impact on California's health by addressing the complex issues that arise in social, economic, and policy infrastructure. The United States-Mexico Border Region, which in its entirety spans four American and six Mexican states and has a population of 13 million people, offers an exciting laboratory for such projects—an opportunity for TCWF to encourage an "out of the box" approach built on binational cooperation, bicultural understanding, and the acquisition of knowledge from effective, wide-ranging data collection. It should be the goal of TCWF to expand the focus of current programs, such as Healthy Borders 2010, beyond the mere treatment of disease to include health promotion and prevention, a forward-looking strategy that is, in the final analysis, the only possible long-term solution. Data and solid comprehension of the facts, combined with an understanding of the social and cultural roots of health and a focus on the empowerment of individuals through knowledge and self-sufficiency, should be TCWF's mandate.

In California, the border counties only represent a small portion of the state's population, yet border health issues have a symbolic importance beyond mere numbers because they touch on the politically sensitive debate over immigration. In a larger sense, border health issues foreshadow larger public health issues in an increasing globalized situation. On the California-Mexico border, the first world meets the third head-on, resulting in a unique public health situation: health concerns common to emerging nations—respiratory and gastrointestinal diseases and tuberculosis—jostle with health conditions more frequent in the U.S., such as cancer, heart disease, and diabetes, and behavioral issues like drug addiction, sexually-transmitted diseases, and violence.

Working in the border region requires an understanding of unique social, economic, and policy dynamics. Border areas can, and often do, become sites of conflict and misunderstanding. At the same time, the concept of a border as an impassable boundary is almost meaningless in a state like California, where it is crossed so many thousands of times every day, for so many reasons. The current political focus on illegal immigration is a distraction; most of the cross-border traffic is legal, frequent, and repeated, part of the daily life of a region that has existed as a cultural entity for over 150 years, regardless of lines drawn on paper in far-away capitals. The Southwest border region is culturally similar, despite the fact that it is split between two countries with different judicial, educational, and health systems. This unity-in-division distinguishes the border region from the rest of the country.

The largest conurbation in the entire border region, San Diego/Tijuana, itself differs in some important regards from the rest of this primarily rural area. According to the 2000 U.S. Census, while most border counties in Texas, New Mexico, and Arizona are predominately Hispanic, San Diego County is a glaring exception: predominantly (55%) white non-Hispanic. Only 27% of the county's population is Hispanic; with 8.7% Asian, 5.5% African-American, and 0.5% Native American. Twenty seven percent of the total county population is foreign born, although in California as a whole, 26% are foreign-born—more than twice the national average. Fifty two percent of the county's foreign-born population is from Latin America. Neighboring Imperial County—in which 23% of the population lives in unincorporated areas—is more like

the rest of the border region, in that approximately 72% of residents are Hispanic, and 20% are white non-Hispanic. Here, a slightly larger percentage (32.2%) of the population is foreign-born, but 95% of that group is from Latin America. In the county's largest city, Calexico, 95% of the population is Latino[1]. In the four-state border region, some 49% of the population is Latino, primarily of Mexican origin. Nineteen percent of U.S. border residents live below the federal poverty level, as compared to 13% of the entire U.S. population[2].

Two major dynamics affect life in the border region, and they have important ramifications for public health. The first is *Cross-Border Resonance*. In general, border towns are paired: Brownsville-Matamoros, Laredo-Nuevo Laredo, Eagle Pass-Piedras Negras, El Paso-Ciudad Juárez, Nogales-Nogales, San Ysidro-Tijuana. In almost all cases, the Mexican town is significantly larger than its American partner. Because of the transparency of the border, the smaller American town "resonates" with the issues of the larger city. This resonance can be seen in health issues.

We can compare two California towns, quite similar on the surface, but very different in terms of Cross-Border Resonance. Arvin, about 20 miles south of Bakersfield in the Central Valley, is a poor, rural town of 13,000, about 88% Latino. San Ysidro is a poor town of about 28,000, like Arvin about 89% Latino[3]. Their demographic similarity might lead one to assume that programs that work in Arvin easily could be applied to San Ysidro. However, San Ysidro is only a mile away from Tijuana, and this makes it a very different place from Arvin.

Arvin is so isolated from the outside world that even what happens in nearby Bakersfield—much less faraway Los Angeles—affects life there very little. An HIV outbreak in Los Angeles or Bakersfield, for example, will have little direct effect in Arvin. In contrast, San Ysidro unavoidably resonates with the dynamics of much-larger Tijuana, population 1,300,000. While Arvin probably receives a handful of outsiders on a given day, San Ysidro receives 155,000 visitors from across the border *every day*, 56.6 million each year—more daily visitors than the entire population of Santa Barbara. Approximately 95% of these daily border crossings are day trips made by Mexican citizens, coming to shop, work, go to school, see friends, visit families, or attend sporting events[4]. Illegal immigration, a much-misunderstood phenomenon, accounts for very little border traffic.

The second significant dynamic that shapes life in California's border region is *Policy Blowback*. Simply stated, the border regions bear the brunt of many foreign policy decisions and government initiatives. Like a funhouse mirror, the border region reflects a distorted version of American policy toward Mexico and Latin America. The North American Free Trade Agreement, now over ten years old, illustrates this concept. When NAFTA opened the economic borders of Mexico, the U.S., and Canada, corn—a staple of the Mexican diet—which was grown cheaply in the U.S. thanks to the heavy use of mechanization, chemicals, and irrigation, a good deal of which was subsidized by public monies, flooded into Mexico. Mexican small farmers, without access to capital and land, were priced out of business. They moved north, hoping to find a spot in the *maquiladora* industry of northern Mexico. The *maquiladoras*, of course, were themselves a response to the earlier entry of Mexico into the General Agreement on Trade and Tariffs (GATT), which offered cheap labor to U.S. manufacturers who would build factories in Mexico. But just as American factory workers lost jobs to low-paid Mexican laborers after

GATT, Mexican *maquiladora* workers now have lost many of their jobs, as U.S. manufacturers find even cheaper labor in Asia. The *maquiladoras* no longer can absorb displaced agricultural workers. The high levels of poverty in San Ysidro are dwarfed by even higher levels of poverty in Tijuana. The issue of poverty in San Ysidro cannot be addressed in isolation from the poverty in Tijuana, a result of NAFTA blowback.

American policy blowback has an even more ominous face in Tijuana. For over a century, Tijuana has been a haven for U.S. citizens seeking to engage in activities restricted at home: cheap sex, alcohol, or gambling. Much of Tijuana's stunning post-World War II population growth was driven by north-of-the-border demand for these pursuits, and many of those displaced in Mexico's interior fall into Tijuana's illegal activities trade. In recent years, the insatiable U.S. demand for drugs, coupled with a dysfunctional U.S. interdiction policy, has allowed narcotrafficking and its violence to become deeply embedded in Tijuana, weakening governance structures and civil society. If the issues of violence and teen pregnancy—not to mention alcohol and tobacco use, casual sex, and related health concerns—are to be addressed in San Ysidro, the blowback effect of U.S. policy cannot be ignored. Poverty in San Ysidro cannot be addressed without considering U.S. and Mexican policies that lead to abnormally high poverty rates in Tijuana, just one mile away.

2. Subcomponents of the Health Issue

Border health is a complex and controversial issue, exacerbated by significant environmental challenges, such as an insufficient sanitation infrastructure and exposure to air pollution and agricultural pesticides; socioeconomic factors, such as widespread poverty and lack of access to health care; frequent movement between countries; and different medical traditions in terms of diagnosis, treatment, and practitioner training. In addition, in the post-9/11 political climate, any discussion that involves either immigration or public transmission of disease has become extremely charged. As a result, there is still much to learn about the border population and its health patterns. In evaluating demographic data, we have identified three population segments in California's border zone. Understanding them may provide a sensible way of assessing the public health challenges the region offers:

Sedentary: Those individuals or families who have established residency in cities near the border and do not migrate across the border in either direction. These individuals essentially have claimed residency and assimilated to the culture around them. They are the most likely to have some form of access to health information and health care through a clinic, local county hospital, or a private hospital, if they have adequate health insurance. They are most likely immunized against the "third world" diseases prevalent in the region and have health issues that affect the majority of Americans: heart disease, stroke, cancer, or obesity. Their exact health status has not been determined on a population basis.

Mobile Sedentary: This group, the majority of the border population, is distinguished by both south-to-north and north-to-south flow. Many Tijuana families, for example, divide their lives between the two countries. They work in the U.S., at minimum-wage jobs that generally do not provide any health insurance, but they live in less-expensive Tijuana and naturally seek health

care there. Other families live north of the border, but travel south for education, goods and services, family reunions, fiestas, and health care. The health status, lifestyle, and health indicators of this group may be similar to the more sedentary population, with whom they interact frequently. But while they are at risk for many of the same "first-world" diseases affecting the Sedentary population, they are at much greater risk of contracting communicable diseases. They are also less likely to have the Sedentary population's easy access to valuable health information through health care providers. Efforts to increase health knowledge and access to health care should be concentrated on this population, to ensure that proper health knowledge—rather than disease—is spread on both sides of the border. Again, the health status of this population is not known on a population basis.

Transient: The target of the undocumented immigration debates, these individuals and families frequently cross the border to seek employment as migrant laborers in areas like Imperial County, areas farther north in California, or in other states. They are the hardest group to track, and they doubtless have the greatest unmet health needs. Transients have little representation and few community resources, as they live only temporarily in the border region. Yet, they face the most complex environmental and occupational health hazards. And while the Transient population is a very small segment of the border population, a great deal of policy attention is spent dealing with its perceived health concerns, primarily to ensure that transients not be attracted to California by the provision of services.

Still, the health of this group has a significant impact. Transients have contact with the Mobile Sedentary group on their way to find employment, and once they have arrived at their destination they mix with the Sedentary population there. Thus communicable diseases can pass quickly within a community via this small Transient population.

3. Funding

Funding for border health seems to be spent primarily on capacity building or on direct services. Most of the direct service monies in this area are devoted to HIV and Tuberculosis. Other funding goes to capacity building of health institutions or programs in San Diego and Imperial counties. The state of California funds very little research in this area.

The *U.S.-Mexico Border Health* website (http://borderhealth.raconline.org) is the best source of comprehensive information on border health funding. The website also includes information on grant-writing for health projects, health topics, links to health agencies in each border state, an overview of federal activities, and a searchable resource database. Much of the information provided in this section came from the *U.S.-Mexico Border Health* website.

The U.S. federal government does offer a few funding programs, although not all of them have to do with health. Here a list of some of the federal assistance programs we found:

- Community Development Transportation Lending Services (CTAA): Provides loan funding to support transit services in rural areas.

- Compassion Capital Fund Targeted Capacity-Building Program: Grants are to be used to increase the capacity of faith-based and community organizations to provide social service programs for rural residents, at-risk youth, and the homeless, as well as marriage education services.

- Health Promotion Among Racial and Ethnic Minority Males: The purpose of this initiative is to stimulate and expand research in understanding the factors influencing the health-promoting behaviors of racial and ethnic minority males. It is not clear that this approach understands the unique features of border health, and it tends simply to apply Healthy People 2010 goals to this region.

- Helping Outreach Programs to Expand Grant Program: Funding to grassroots community- and faith-based victim service organizations and coalitions to improve outreach and services to crime victims, through support of program development, networking, coalition building, and service delivery.

- Robert Wood Johnson Foundation Research Proposals on Disparities Issues: Grants for research proposals that offer solutions to health care disparities. The Robert Wood Johnson Foundation seeks to reduce racial and ethnic disparities in the care of patients with cardiovascular disease, diabetes mellitus type 2 and/or depression.

The private sector and private foundations are major sources of border health funding. A complete list of funding programs available from these foundations can be found at the *Border Health* website. In California, some of the most active are:

- Alliance HealthCare Foundation Grants: Alliance HealthCare Foundation focuses on improving the health care delivery system for the medically underserved in San Diego County.

- California Endowment Grant Programs: Grants to expand access to affordable, quality health care for the underserved and to improve the health status of all Californians.

- California Wellness Foundation Grants: Funds for direct preventive health services, core operating support, community action, public education, and public policy.

- San Diego HIV Funding Collaborative (SDHFC): Grants to programs that fill gaps within San Diego's HIV/AIDS service delivery system.

- Wells Fargo California Grant Program: Wells Fargo makes grants in three primary areas: human services, education and community development.

It should be pointed out that funding is available primarily for the treatment of diseases or prevention of vector-borne disease. There is very little funding available for health promotion or disease prevention, especially for those health problems resulting from social, economic, and policy infrastructure on the border region.

4. Public Opinion

Judging by available public opinion indicators—from talk radio and letters to the editor to legislation and initiatives—the issue of border health has become nearly completely subsumed into the general public discourse about immigration. Every day, radio talk shows spew out concerns about "anchor babies" resulting from Mexican mothers sneaking across the border to give birth in California, to provide a "back door" for illegal immigration and welfare abuse. Letters to the editor in local English-language papers typically describe emergency rooms filled with undocumented patients, although the writers never specify how they verify a patient's documented status, particularly as hospitals do not ask this question. Legislation at the federal, state, and county levels is caught up in this rhetoric. For example, the 2006 California state budget was held up temporarily by anti-immigrant legislators who felt that expansion of a child health insurance program would allow coverage for undocumented children, and who were willing to sacrifice the entire budget to this one issue, in spite of the fact that 93% of Latino children in California ages 0-15 are U.S. citizens. Initiatives such as Proposition 187 in California and the more recent Proposition 200 in Arizona reflect this public discourse of limiting access to perceived undocumented.

As a result, while most of the U.S. public is in high dudgeon about immigration, the health of the border region itself is not registering as an independent issue. We could not find any recent, population-based survey data on public opinion about border health. At some point, some relevant questions could be added to on-going general surveys, such as the Field poll, to provide some data about border health independent of the debates about immigration. Such questions might include:

- Measurement of the strength of "bunker mentality," which refuses to consider public health programs out of fear they would attract undocumented immigrants;
- Perceptions of specific issues popular in talk radio discourse, *e.g.* "anchor babies," cross-border use of services, etc.
- Awareness and perceptions of the economic importance of cross-border economic activities.
- Awareness of impact of U.S. policy on Mexico.
- Awareness of Mexican perspectives on border issues

The greatest impact that TCWF could have, not only on border health but on the general health policy discussion in California today—which is rapidly skewing towards viewing health programs merely through the lens of undocumented immigration—would be to use the Foundation's tremendous convening power as a "bully pulpit" to reshape the public's opinion about health in 21st- century California. Currently, there are no public voices balancing talk radio, nightly diatribes on television, and torrents of letters to the editor. The result is that the "undecided voter" often assumes that such audible and visible public discourse must be

essentially correct, as no one offers another view to counter the perception that undocumented immigrants represent the greatest threat to the state's health and health services.

An orchestrated public education program that separates border health from the immigration hysteria could go a long way towards creating a public opinion climate that would allow reasoned policy and program development for the health of the border region. Only an entity such as the California Wellness Foundation is capable of creating such a pubic opinion change of this magnitude, and such a change would have a great impact on policy debates in this state, not just on border health but also on a wider range of issues.

5. Public Policy

As a result of the deafening din about immigration, current public policies threaten to create a situation in which reasoned policymaking about border health may be next to impossible. Current perceptions include:

- *Increasing access to care attracts undocumented immigrants*. Overall, this idea, vigorously discussed at the federal, state, and local levels, serves to chill nearly any discussion about increasing access to services, including private sector efforts (*vide* the Health Net experience below). The new federal policy requiring proof of residency for Medicaid eligibility may freeze citizen children of undocumented parents out of Medi-Cal. State attempts to have providers identify the undocumented may likewise cause a chilling effect in seeking services.

- *Immigrants as costly burden*. This is an old argument, dating from the 1930s, that ignores the tremendous economic boost given to the state and national economies by immigrants and completely overlooks the vitality of border economic activities that rely upon the Mobile Sedentary population segment. This policy area is driven by states, often responding to self-appointed border security groups who argue that the federal government should bear the costs of care for the undocumented, often without much specification of what those costs are. The federal level does not respond, as it is too focused on issues of security and border control. The counties are caught in a bind between federal and state governments. Meanwhile, lost in the debate is the fact that Mexican citizens in the border region are far more likely to use services in Mexico than in California; pregnant women in Tijuana generally do not cross into the U.S. to give birth so that the family can later qualify for welfare.

- *Immigrants as vectors*. This fear that "unhealthy" Mexican immigrants possibly might contaminate healthy Californians is an old argument, used to good effect during the 1918 flu epidemic to segregate, then later deport, Latinos. The corollary notion is that if the state does not increase access to services, the Mexican vectors will not be attracted to California.

We would suggest that the California Wellness Foundation visualize its mission statement operationalized to the realities of the border region. What would it look like if teen

pregnancy and violence, for example, were to be reduced, and wellness promoted, in SanYsidro, given that many of the problems are impacted by social, economic, and policy infrastructures one mile away in Tijuana. How could appropriate policies be developed?

In California, some key organizations currently conducting research and gathering data to affect future policy in regards to border health are:

- California Wellness Foundation
- California Endowment Foundation
- California Office of Binational Border Health.
- Center for U.S-Mexican Studies, University of California, San Diego
- Center for Comparative Immigration Studies, University of California, San Diego
- California-Mexico Health Initiative
- San Diego-Tijuana Border Initiative
- Public Health Departments of San Diego and Imperial Counties

National organizations include:

- US-Mexico Border Health Association
- US-Mexico Border Health Commission, California Outreach Office

6. Knowledge

As a local, regional, and binational issue, border health is so broad a topic that comprehensive knowledge has not yet been fully developed. It is particularly difficult to gather information on the binational aspects of border health. Due to the frequent traffic between countries, working on one side of the border alone is bound to yield incomplete information. We lack an integrated theoretical model to serve as a strategic framework; the focus has been on narrow activity areas—immunization, sewage projects, HIV treatment, development of individual clinics—rather than an overall plan. Even data collection has been focused on treatment data rather than on underlying social causes that contribute to health conditions.

Agencies need to gather epidemiological data that will yield an accurate portrayal of the border population groups—the Sedentary, Mobile Sedentary, and Transient—and their various health needs. Admittedly, it is difficult to gather data on the many border residents in mixed-status families who suspect that any personal information may find its way to the Immigration and Naturalization Service (INS). Thus collection of border region data requires a certain sensitivity, which suggests the importance of a binational collaborative network to help with appropriate data collection and surveillance. This collaborative network could also work on cultivating relationships and jointly addressing health issues with agencies south of the border. In general, little use is made in this country of Mexican research, policies, and programs.

In addition, information gathered by key agencies in San Diego and Imperial counties seems to be poorly coordinated. It is understandable that there is competition among agencies for grants and research monies; a coordinated effort may guarantee better communication and collaboration and address the diverse needs of both counties without duplicating the work.

7. Levers of Change

In the post-war years, 1945-1985, the levers of change were in the hands of public health officials and staff—providers, educators, epidemiologists, sanitarians—who set the agenda for border health activities. These tended to be very concrete activities that dealt with health problems that had already arisen, such as improvements to sewage systems and vaccination campaigns. Beginning with the Immigration Reform and Control Act in 1986, however, the levers of power passed into the hands of anti-immigrant policy activists—legislators, lobbyists, talk-show hosts, and vigilante groups such as the Minutemen—who tend to view nearly any proposed legislation through the lens of illegal immigration.

Recently, a new set of actors has put their hands on the levers of change, but these have not yet become part of the general public debate. These are found in the private sector, particularly insurers and employers. Insurers such as Health Net and Blue Cross are developing cross-border products, which allow for coverage in one country and use of services in the other. Health Net's Mexi-Plan builds upon natural flows and needs by offering coverage with a very low premium, under $100 per month, if elective services are sought in Tijuana with a contracted provider. This plan offers to bring thousands of Latino families under insurance coverage without use of public dollars, and it could go a long way toward answering the pressing need of the uninsured population. Yet when the program was introduced on English-language news, it was castigated by an anti-immigrant spokesperson as creating a program that would attract and benefit undocumented immigrants. This spokesman apparently had too little understanding of the life of illegal residents to realize that the difficulty of returning to the U.S. would effectively discourage illegal residents from using this plan. He had his hand on a lever of power and then used it not to effect change, but try to block it.

Employers in industries that rely upon immigrant labor rarely have raised their voices in the debates about their employees' health. Private-sector employers in manufacturing, construction, agriculture, and services that employ the cross-border Mobile Sedentary population might be persuaded to use their economic influence as levers of change. Their voices need to become part of the debate, or the debate can threaten their employees and businesses. Added to this mix could be more rational policy voices, such as the National Council of La Raza and the Mexican American Legal Defense and Education Fund.

In short, today's public media are effectively blocking rational discourse on the issue of border health. But other voices are beginning to counterbalance them and eventually may allow border issues to be tackled independently of the immigration debates. The greatest single indicator of success would be a conceptual one: the ability of border health to be considered and debated as an issue separately and independently of the debates about immigration.

8. Other Commentary

We would like to emphasize, once again, the potential power an entity such as The California Wellness Foundation has to balance current public debates about the health policy consequences of immigration, so that reasoned policy development can take place. Absent such a separation of these two issues, it is our fear that border health will not be able to gain its place in

the policy sun as an independent issue. By funding programs that support cross-border collaboration and accurate data collection about the three border population groups, TCWF can make a meaningful contribution to an issue that will only grow in importance as the century progresses.

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4 – Morris, Ken. *Moving Toward Smart Borders.* Prepared for San Diego's Forum *Fronterizo* program. June 2003.