Access to Health Care in the U.S.-Mexico Border Region: Models, Research, Policy and Action

Policy Forum Executive Report

April 2005

Funding provided by the U.S.-Mexico Border Health Commission

United States-Mexico Border Binational Health Week: Families in Action for Health
### TABLE OF CONTENTS

*List of Sponsors, Co-sponsors, and Support Organizations*

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>List of Sponsors, Co-sponsors, and Support Organizations</td>
<td></td>
</tr>
<tr>
<td>I. Executive Summary</td>
<td>1</td>
</tr>
<tr>
<td>Participants</td>
<td></td>
</tr>
<tr>
<td>Outcomes</td>
<td></td>
</tr>
<tr>
<td>U.S.-Mexico Border Health Policy</td>
<td>5</td>
</tr>
<tr>
<td>Presentation Summary</td>
<td></td>
</tr>
<tr>
<td>II. Recommendations</td>
<td>20</td>
</tr>
<tr>
<td>III. Faculty, Moderators, Planning Committee &amp; Translation</td>
<td>22</td>
</tr>
<tr>
<td>IV. Participant List</td>
<td>25</td>
</tr>
</tbody>
</table>
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Healthy Community Access Program,
Health Resources and Services Administration
I. Executive Summary

The Policy Forum, “Access to Health Care in the U.S.-México Border Region: Models, Research, Policy and Action” took place in El Paso, Texas on October 14-15, 2004. It was organized through a multi-agency collaborative effort as part of the Border Bi-national Health Week to strengthen networks among by medical providers, consumer advocates, and legislative representatives from local, state, and national government from both countries. The long-range goals were to (1) better address existing barriers to medical services, and (2) strengthen bi-national medical safety nets.

This Executive Report summarizes the majority of Presentations, introduces outcome Recommendations, and includes a Participant List\(^1\). Compact disks have been distributed that contain session transcriptions (with selected translations), PowerPoint presentations, and photographs. Forum materials help document the border epidemiology and health service discussions, and will be posted to the U.S.-México Border Health Commission website (www.borderhealth.org).

Thirty-five border health and policy experts spoke at the Forum; twenty-eight of their presentations were transcribed (21 in English and 16 in Spanish) and are included on the compact disk with eighteen MS-PowerPoint presentations (13 in English and 5 in Spanish). Forum topics included:

1. **Infrastructure and Workforce**
2. **Health Workforce Education**
3. **Medicare Improvement Act**
4. **Pharmacy Products & Services**
5. **Border Health Policy**
6. **Health Care Workforce**
7. **Border Health Services**
8. **Innovation and Quality**

\(^1\) Six Forum presentations were not summarized due to recording equipment problems and because PowerPoint presentations were not used.
Participants

One hundred fourteen (114) people from both countries registered at the Forum including health care leaders, border health experts, researchers, state legislators, and national legislative staff members. The majority of participants (85%) were from the U.S. creating, perhaps, an emphasis on U.S.-relevant outcome recommendations. Table 1. describes Forum participants.

Table 1. Forum Participants by Organization Type and Region

<table>
<thead>
<tr>
<th>U.S. and Mexican Organizations</th>
<th>Region</th>
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<td>Federal Govt.</td>
<td>Baja California</td>
</tr>
<tr>
<td>State Govt.</td>
<td>Chihuahua</td>
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<tr>
<td>Local Govt.</td>
<td>Sonora</td>
</tr>
<tr>
<td>Non Governmental Org.</td>
<td>Colima</td>
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<tr>
<td>Academic</td>
<td>México D.F</td>
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<tr>
<td>Health / Medical Providers</td>
<td>Nuevo León</td>
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<tr>
<td>Other</td>
<td>New México</td>
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<td></td>
<td>Arizona</td>
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<td>Total</td>
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<td>114</td>
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Outcomes

Due to time and resource limits, Forum organizers did not evaluate change in participant knowledge related to their participation in the Policy Forum. However there is anecdotal evidence that supports the conclusion that change did occur. For example, representatives from the Border Legislative Conference Health Work Group met during the Forum and members learned how U.S. Border States are acting to curb excessive alcohol consumption among border (primarily U.S.) youth. Subsequently, state legislation was introduced in Arizona by a Forum participant to control the number of youth who cross the border without adult supervision. Another outcome is the inclusion of multiple umbrella groups in the planning of U.S.-México bi-national legislator events (i.e. Border Governor’s Conference).

Twelve Policy Recommendations were generated reflecting participant opinions concerning emergent border health service priorities (Refer to page 4).

U.S.-Mexico Border Health Policy

Forum speakers provided examples of bi-national cooperative approaches to ensuring health care access in both countries. One example described a medical provider directory created by the Sonoran Ministry of Health to identify physicians authorized to write prescriptions in México. This Directory is passed along to Arizona pharmacies and used in Arizona when filling prescriptions written by Mexican physicians.
Model programs do exist that harmonize services between countries. However health policy continues to primarily be a unilateral federal and state activity. That is, health policies are established in each country by governments in response to national and state political and technical conditions. Health services emerge that look very different based on resources, institutional authority, strategic priorities, political values, and, not the least, constitutional and legal mandates. National policy processes developed in a unilateral manner create bi-national differences and challenge bilateral collaboration. At the border, an environment emerges where local conditions “refract” the legal and policy considerations and create a unique operational environment. Bi-national environments stimulated by bilateral health service interactions foster programs that respond to local border conditions. However, bi-national services may not always be fully consistent with federal policy, in either country.

Border health services should be allowed to develop in response to community dynamics and local conditions. Border health policy should be crafted to allow local institutions and services to respond best to local community dynamics. Border health programs that remain rooted in unilateral national politics and institutional policy will create service gaps. Fortunately, policy models have been emerging that foster bilateral approaches. These models engage local legislators, border state governors, and border health policy leaders through the U.S.-México Border Health Commission, the Pan American Health Organization, the Border Governor’s Conference, and the Border Legislative Conference. As these efforts develop, new challenges will likely emerge to coordinate these umbrella efforts.

Clearly, border health services need to become more efficient as resources are limited. We should not continue to address half of the border community expecting to solve a whole problem. Nor should we continue to target a growing and frequently mobile population with static health interventions.

The border region has many diverse health care resources. However, structurally, these services are frequently isolated and poorly distributed. Forum participants recounted situations residents who could not gain access to needed medical care because of fear, misinformation, or misdirected policies. While a great deal of progress has been made during this past decade, there remains significant room for improvement. Powerful barriers remain to delivering healthcare in a bi-national region and we lack the evidence necessary to make informed, strategic decisions. The Policy Forum seemed to reflect a consensus for moving forward, through bilateral engagement at the state and federal levels, all the while keeping the focus on local community conditions. Border residents and healthcare professionals need to drive border health policy. Future efforts, as described by several Forum speakers, should strive to build a health infrastructure that takes advantage of the health care diversity that exists to improve access to quality medical and preventive services. It can be done.
## Table 2. Policy Forum Recommendation

<table>
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<tr>
<th>Topic</th>
<th>Recommendation</th>
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</thead>
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| **Infrastructure and Workforce**  | 1. Organize a U.S.-México border site visit for legislators and staff members to visit the border and get to know first-hand about the challenges and opportunities of delivering health care in a bi-national region.  
2. Organize an educational summit on border health for Congressional members and staffers in the nation’s capitals.  
3. Call upon the U.S. Surgeon General to publish a Report that documents border community health status, establishes measurable baselines for priority problems, and outlines future health policy directions.  
4. Call upon HRSA’s Office of Rural Health Policy to replicate the Rural Assistance Center expanding services to border health professionals and to provide resources to seed and test service models, such as a border community Ombudsman Program.  
5. Call upon technical experts from the Pan American Health Organization to help assess the capability of U.S.-México border communities to perform essential public health services and functions.  
6. Disseminate a (border-wide and bi-national) catalog of health professional training opportunities that provides certification and encourages cross-training, offering exposure to the other country’s health care system for students and professionals.  
7. Support emerging border health coalitions (i.e. border state medical associations, border hospitals, etc.) through the annual production and dissemination of a Border Health Directory to include coalitions, medical providers, public health and advocacy groups including federal, state, and local listings.                                                                                                                                                                                                                                                                                                                                                   |
| **Health Workforce Education**     | 8. Call upon the U.S. Center for Medicare and Medicaid Services (CMS) to organize training and support services that encourages border hospitals to pursue reimbursement for emergency care provided to undocumented people.                                                                                                                                                                                                                                                                                                                                                     |
| **Medicare Improvement Act**       | 9. Speed development of bi-national disease reporting systems, replicating the lessons learned from the tuberculosis control model system to maternal health, immunization, and HIV/AIDS treatment and control.                                                                                                                                                                                                                                                                                                                                                                           |
| **Innovation and Quality**         | 10. Request that the Mexican Ministry of Health complete a feasibility assessment to enable access to Seguro Popular for Mexican citizens living in the exterior.                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| **Access to Health Care**          | 11. Call upon the Food and Drug Administration, working with Mexican counterparts, to create a bi-national agreement that enables both countries to share pharmacy product information and determine the therapeutic equivalence of medications.  
12. Call upon the Food and Drug Administration to work with border researchers to evaluate and document pharmacy product quality and disseminate information that educates the public concerning any risk associated with crossing the border to purchase pharmacy products.                                                                                                                                                                                                                 |
Presentation Summary

Inaugural Overview

Rosemarie Marshall Johnson, MD
Member, U.S.-México Border Health Commission

Dr. Marshall welcomed Forum participants on behalf of the U.S.-México Border Health Commission. She brought to participant attention the Commission’s last Annual Report that included a series of health policy recommendations presented to the two governments addressing major health needs: improving access to healthcare, providing health education and disease prevention, and encouraging development of health infrastructure. Dr. Marshall spoke about the Commission’s federal and state advocacy activities and she emphasized the need to be strategic in moving forward. Dr. Marshall Johnson described a program being carried out with Commission support, Ventanilla de Salud. This program, implemented in southern California’s Mexican Consuls, employs health educators to provide health education and information about healthcare services. Participants trust the educators because the program takes place at the Consulate. Dr. Johnson also identified the need for health service “Ombudsman” who could provide information and help people better navigate the health and social service systems.

Joxel García, MD, MBA
Deputy Director, Pan American Health Organization

Dr. García spoke about PAHO’s role as “Convocatoria”, bringing major policy players together in partnership with the U.S.-México Border Health Commission and other national entities. He emphasized that policy-development shouldn’t “begin from the beginning” because program models are in-place, a great deal has already been learned, and there exists a cadre of health professionals who have dedicated years to understanding how border programs work. It would be wasteful to re-invent wheels when the more productive approach is to: (1) identify priority problems, and (2) establish valid baseline estimates that enables policy makers to evaluate program effects and change. Dr. Garcia called on participants to rely on documented program evidence, not solely on their impressions and intuitions of success. According to Dr. Garcia, it’s time to measure ourselves because, “no matter how great we think we are, we still need to look at ourselves in the mirror for an honest assessment whether we’re representing a constituency and protecting our communities”. He emphasized that the national healthcare leadership in both countries has expressed support for border health during the Border Bi-national Health Week.

Infrastructure and Workforce

Marcia Brand, PhD
Director, Office of Rural Health Policy (OHRP)
Health Resources and Services Administration

Dr. Brand noted that ORHP was recently assigned responsibility for HRSA’s border health programs and she identified infrastructure challenges characteristic of rural and border areas. Among these are transportation and geographic distance, grantsmanship
capacity, and the distribution of healthcare providers. Dr. Brand spoke of the program resources available through the Department of Health and Human Services (DHHS) and emphasized her commitment to ensuring that border health professionals have access to DHHS services and resources. She noted that OHRP is currently testing rural health care delivery models and proposed replicating efforts such as the Rural Assistance Center for border programs so that health professionals could more easily connect to information and resources. Dr. Brand asked participants to engage OHRP concerning border problems. She also emphasized that while infrastructural deficits are evident, the border represents a region of immense health care opportunity. She note that all cultures, all political parties, and all countries share values concerning health and that the U.S.-México border provides a unique opportunity to achieve shared goals. Borders don’t have to divide us; borders can unite communities.

Miguel Angel Fernandez Ortega, MD
Department of Family and Community Medicine, Autonomous University of México

Dr. Fernandez Ortega spoke about education, supply and distribution of physicians in México. He identified 83 schools of medicine where approximately 15,000 medical students enroll each year. Medical training lasts 6-to-7 years depending on the school and, each year, about 10,400 students graduate as general practitioners. There are 142,765 physicians practicing in México and, (in 2002) about 180,000 nurses. In the 6-northern Border States, there are 21,364 practicing physicians. Medical school graduates can apply for post-graduate programs, which requires an additional 3-5 years depending on the specialty. The Autonomous University of México (UNAM) offers 75 specialty areas and specialists are required to re-certify every 5-years. In México, there are 45,249 medical specialists who practice in the public and private sectors. The largest number of specialists includes pediatrics, family medicine, general surgery and anesthesia; the smallest number includes infectiolgy (N=106), neurophysiology (N=91) and Aerospace medicine (N=60).

Guillermo Mendoza, MD, MPH
Program Officer, Alliances for a Healthy Border Program Pan American Health Organization, U.S.-México Border Field Office

Dr. Mendoza summarized two PAHO reports concerning the availability of health resources along the U.S. México border. The Reports, published last year, include data from both countries concerning demographics, health coverage, human resources / workforce, facilities / physical resources, and financial resources. Copies of both reports are available on-line (www.fep.paho.org). Due to time limits, Dr. Mendoza was only able to present the initial sections concerning border population growth, healthcare coverage, and healthcare resources including the distribution of healthcare providers. The information presented shows the unique characteristics of the border including emerging patterns of healthcare disparity among U.S.-border community populations when compared to U.S. national averages. For example, Dr. Mendoza reported that in 2000, 14.6% of the U.S. population lacked any type of health insurance compared to 28.5% of the border county population. The two PAHO Reports, Diagnostic Summary of Health Care Services Vol. I & II, provide an in-depth assessment of healthcare needs and available resources.
Health Workforce Education

Steve Shelton, MBA, PA-C  
Executive Director  
East Texas Area Health Education Center

Mr. Shelton provided a summary of medical and nursing education standards in the U.S. He identified 120 accredited schools of allopathic medicine and 20 schools of osteopathic medicine and discussed school application and acceptance processes together with curriculum standards and post-graduate training opportunities. Mr. Shelton noted that 1700 nurse education programs exist in the U.S. ranging from graduate and undergraduate programs to associates degree and certificate programs. Nursing curriculum standards were identified.

Noemi Alcaraz     Patricia Salazar Diaz
Director, School of Nursing   Director, University English Program
University of Colima   University of Colima

Ms. Alcaraz and Ms. Salazar Diaz introduced México’s healthcare system and described three major parts including the Social Security System, the Public Health System and Private Provider System. They estimated that 50% of the healthcare is provided through Social Security, 40% through the Public Health System, and 10% by private providers. The two agencies with primary responsibility for regulating health training are the General Health Council and the National Health Council. Currently, México has registered 141,000 physicians and 190,000 nurses and, while the numbers have been increasing overall, the increase per population is lower for nurses. The physician/population ratios range from 2.5/1,000 (in communities of low-marginalization) to 0.13 / 1,000 (in indigenous areas such as Oaxaca). Nationally, there are 1,033 health professions training programs including 509 in medicine and 300 in nursing. Physicians have a 6th year of post-graduate requirement that requires them to dedicate one-year of social service to underserved communities. In 2000, a voluntary certification in nursing was instituted and between 2000-2003, 4017 nurses became certified. Nursing curriculum and accreditation issues were also discussed.

Rosemarie Marshall Johnson, MD
California Medical Association

Dr. Marshall introduced several legislative initiatives intended to address practitioner shortages in California. Due to retirement and practice changes, California is experiencing a significant reduction in physicians, which is having an acute effect in underserved and border communities. Dr. Marshall referred to a 2002 California Law that created a pilot project where 30 Mexican dentists and physicians could practice in clinics for the underserved. She acknowledged concern expressed by Mexican colleagues about a possible “brain drain” associated with this program and concern expressed by the State’s Medical and Dental Associations about quality standards. Because of the complexities and controversies, this program has not yet been implemented. She also discussed other California legislative initiatives including the SMT Physician Corps,
which has already placed 50 physicians in underserved areas since July 2003. Dr. Marshall also spoke about the roles that the four U.S. border state medical associations have assumed in support of border health. She noted being part of a American Medical Association (AMA) and border state Medical Association Delegation that went to Washington DC to educate and advocate for border health resources.

Lynn Wegman, MPA
Chief, Division of State, Community, and Public Health
Bureau of Health Professions, HRSA

Ms. Wegman provided an overview of health care training in the U.S. offering a schematic model where: Workforce Planning and Analyses -> The Right People; High Quality Education -> The Right Skills; Equitable Distribution -> The Right Places; and Performance/Outcome Measures -> The Right Outcomes. She introduced the Bureau of Health Professions, whose mission is “to improve the health status of the population by providing national leadership and resources to develop, distribute and retain a diverse, culturally competent health workforce that provides the highest quality care for all, especially for the underserved.” Ms. Wegman spoke about the Texas, New México, Arizona, and California Area Health Education Center (AHEC) and the Health Education Training Center (HETC) programs that organize health professional training opportunities and community health education services. These initiatives have made a major contribution to strengthening the border health infrastructure.

Medicare Reimbursement Act

David Austin
U.S.-México Border Counties Coalition

Mr. Austin provided a historical context for how the Section 1011 received federal funding under the Medicare Improvement Act. He described how the Border Counties Coalition completed a Study in September 2002 titled: Report on Uncompensated Emergency Health Care” (available at www.bordercounties.org). The Study estimated that 24 U.S. border counties were incurring $200 million costs annually to treat undocumented immigrants in emergency care settings. This estimate was made only for initial emergency care and did not include any post-stabilization efforts or doctor/physician costs. The costs associated with emergency care provided to undocumented persons represent about 25% of the total uncompensated care provided in border counties. The Border Counties Coalition Study estimated that the total cost of uncompensated care from all sources would total more than a billion dollars. Mr. Austin described the coalition-building efforts that resulted in the eventual approval of Section 1011 including the development of a border hospital coalition. He concluded that effective border health advocacy is supported by collaboration and identifying priorities that help the border’s diverse constituencies speak with a single voice.
Jim Bossenmeyer  
*Center for Medicare and Medicaid Services*

Mr. Bossenmeyer discussed the implementation guidance for Section 1011 which provides $250 million annually during a four-year year period (2005-2008) to reimburse medical providers for uncompensated costs associated with emergency care provided to undocumented. The money will be allocated based on state statistics but it will go directly to providers. Two-thirds of the money ($167 million) is going to all states and the District of Columbia based on the Census information about the number of undocumented aliens in that particular state. Another $83 million will be distributed among the six states with the highest number of illegal immigrant apprehensions within a state, over a consecutive four period quarter. The guidance defines eligible emergency care providers, services, and types of individuals who can receive benefits. However, benefits are paid directly to the emergency care providers including hospitals, physicians, and ambulance services to be paid for inpatient and outpatient services associated with treating individuals in need of emergency care.

CMS is currently developing the final guidance that will be published in the Federal Register. One of the critical issues concerns how to “document the undocumented” Of the many options studied, the current indications are to adopt a proxy (indirect) approach. Eligible individuals for services was clearly defined by the statute and includes three different groups of individuals: 1) Mexican citizens coming across on a 72-hour crossing card; 2) Individuals who are paroled into the United States at an eligible port of entry; and 3) Undocumented aliens. Undocumented aliens are in the United States not on legal status, perhaps have overstayed their visa or who arrived without appropriate papers). These are the three groups of individuals eligible for services assuming they don’t already have medical insurance and that medical insurance could include Medicaid, emergency Medicaid, worker’s compensation, a private insurance or they could be a self-pay individual.

Bruce Lesley  
*Health Policy Advisor, Office of Senator Jeff Bingaman (NM)*

Mr. Lesley provided a U.S. federal legislative perspective about the implementation of Section 1011. He expressed two major concerns: (1) Documentation of immigrant status; and (2) Administrative cost. He expressed concern about the immigration determination process and the possible affects of dissuading people from soliciting needed healthcare for themselves or a member of their family. This is significant considering that 85% of immigrant households include at least one U.S. citizen, typically a child. He expressed concern with the initial draft guidance that would have attempted to document the undocumented by asking directly about citizenship status. This could lead people to not want to seek health care and could have a deleterious effect on local communities.

Concerning administrative burden, Mr. Lesley noted there are $250 million (per year) available for the entire nation, an amount that would not even cover border county costs. Providers could only receive 5%-to-10% of the cost of care provided. The administrative cost of pursuing Section 1011 funds should be minor compared to what is reimbursed; the administrative burden needs to be as minimal as possible. Mr. Lesley encouraged all participants to remain active in monitoring the development of CMS’s final guidance.
Innovation and Quality

Rosaly Correa-De-Araujo, MD, PhD
Senior Advisor on Women’s Health
Agency for Health Care Research and Quality

Dra. Correa de Araujo spoke about ARHQ research to improve healthcare quality and identify health disparities. She reported that nationally, Hispanics are more likely to lack health insurance and score lower on two-thirds of the access to healthcare measures, especially those concerning prevention services. Hispanic adults are less likely to receive colorectal or breast cancer screening and to receive influenza or pneumonia immunization. Nationally, Hispanic women tend to receive less pre-natal care and Hispanic low-income children receive less dental care. Hispanic men are less likely to have their blood cholesterol checked or to receive endoplasty. Mexican Americans receive 38% fewer medications to treat heart conditions and are less likely to be counseled to quit smoking. She reported that these disparities are especially evident in U.S.-México border communities given the high proportion of Hispanic populations and people of Mexican decent. There are significant disparities considering access to healthcare and she emphasized the importance of preventive care because chronic disease prevalence is increasing. These diseases are expensive to treat and lead to disability and premature death.

Dr. Hector Murguia
Sub-Secretaría de Innovación y Calidad
Secretaria de Salud, México

Dr. Murguia presented a quality improvement model that is applied to healthcare services in México. He discussed the process of innovation, to break molds and change paradigms that people have become accustomed to and practices that inform the delivery of health care services. To innovate, one must be better prepared to know the relevant questions than to have the answers. Dr. Murguia reported that one of the principal objectives at the Secretary of Health is to guarantee healthcare rights for all Mexican citizens. The Sub-secretary of Health has the mission support healthcare improvement processes in phases: Information, Evaluation, Operational Planning, Innovation/Development, and Improvement. Information systems are essential to understanding healthcare processes. Dr. Murguia described innovation as not only creative thinking but also creating environments that support change and break down barriers to innovation. The Secretary of Health has established a goal that all Mexicans will have access to quality healthcare services within six years. To achieve this goal, big changes will be required. Healthcare workers need to become more efficient due to the time remaining to make improvement.

Dr. Luis Manuel Provencio Olivas
Departamento de la Coordinacion de Calidad
Servicios de Salud de Chihuahua

Dr. Provencia Olivas discussed health services innovation and medical quality improvement as applied within the Secretariat of Health in Chihuahua. He defined quality
as a fundamental value within an organization’s culture. To begin, one must determine whether clinical processes have been determined effective according to existing published evidence. Quality indicators have been developed for the treatment of diabetes, hypertension, prenatal care, acute respiratory infections, and acute diarrhea. Dr. Provencia Olivas provided examples to improving diabetic patient conditions by reviewing laboratory results; delivering physical exams; and monitoring arterial pressure, glycemia, and opportune infections. Another quality improvement study involved prenatal control to reduce the threat of abortion by requiring urine examination. Quality studies are being completed with physicians and nurses to evaluate the quality of care provided. Another monitoring program is the “Treatment with Dignity” where surveys are completed to determine patient waiting time and overall satisfaction. Patients who believe they have been treated poorly are given the opportunity to use the telephone, without charge, to report their complaint. Clients can also go to the website to review medical quality indicators (www.calidadensalud.com). A state-level group is convened to address concerns and make recommendations to improve Seguro Popular.

U.S. Congressional Welcome

Robert Kincaid and Daniel Meza
Legislative Counsel for Senator John Cornyn (TX)

Bruce Lesley
Health Policy Advisor
Office of Senator Jeff Bingaman (NM)

Philip loPiccolo
Senior Field Representative
Office of Congressman Silvestre Reyes (TX)

Gloria Montaño
Office of Congressman Raúl M. Grijalva (AZ)

Representatives from four border legislative offices gave introductory comments on behalf of Senator Jeff Bingaman, NM (Bruce Lesley); Senator John Cornyn, TX (Robert Kincaid and Daniel Meza); Congressman Silvestre Reyes (Philip loPiccolo); and Congressman Raul Grijalva (Gloria Montano). The legislative staff members encouraged the ongoing participation by border health professionals in policy development processes given (1) their technical expertise, and (2) the lack of knowledge of border issues among many federal legislators. Mr. Lesley and Mr. Kincaid both emphasized the significance of developing an educational strategy to inform legislators about the border at an educational summit in Washington, and by organizing a site visit to the border for legislative staffers to learn first-hand about bi-national realities that affect their own regions. The Legislative Staff Members encouraged Forum participants to remain in contact by providing technical comment and assistance on legislative proposals.
Health Care Workforce

Antonio Furino, PhD
*University of Texas, San Antonio Health Sciences Center*

Dr. Furino discussed the Regional Center for Health Workforce Studies (RCHWS), whose mission is to address U.S.-México border health workforce issues and serve the five-state region of Arkansas, Louisiana, New México, Oklahoma, and Texas. The RCHWS was funded to collect, analyze, and disseminate health workforce information that facilitates national, state, and local workforce planning. Dr. Furino emphasized that there exists a great deal of variation between, and within, Border States. This variation challenges the interpretation of aggregated data that is used to inform policy and design interventions. Preliminary results show that health professionals are growing older and retiring but not being replaced at the same rate by a younger health professional cohort. He also reported that primary, dental, and mental health care profession shortage areas are 17%-to-42% greater along the border than the rest of the country. The RCHWS will attempt to maintain bi-national partnerships in order to create a data infrastructure capable of producing timely and accurate longitudinal information that is comparable over time and across space.

Kerry Paige Nesseler, RN, MS
*Associate Administrator for Health Professions*
*Health Resources and Services Administration*
*U.S. Department of Health and Human Services*

Capt. Paige Nesseler spoke about the Bureau of Health Professions (BHRP) whose goals are to: (1) Eliminate Health Barriers, (2) Eliminate Health Disparities, (3) Assure Quality of Care, and (4) Improve Public Health and the Health Care System. The Bureau accomplishes these goals by working to assure an appropriate supply and diverse composition among the health profession workforce. The Bureau supports a wide range of program initiatives, many that serve the border including the Center of Excellence, Health Careers Opportunities Program, and the National Health Service Corps, among others. Capt. Paige Nesseler expressed her continuing commitment to supporting border health activities.

Access to Health Care

Sam Shekar, MD, MPH
*Associate Administrator for Primary Health Care*
*Health Resources and Services Administration*
*U.S. Department of Health and Human Services*

Dr. Shaker spoke about the Bureau of Primary Health Care and the Consolidated Health Center Program. He reported on the (2002) Presidential Health Center Initiative that, by 2006, is expected to create 1200 new or expanded Health Centers that provide coverage to six million people. This represents a daunting challenge given the health professional workforce needs critical to staffing the new centers. If medical practitioners are not available, no one will provide medical care. To achieve the Presidential Initiative goals, 31,000 new CHC staff are needed including 11,000 clinicians (that assumes none leave the Centers where they currently practice). Dr. Shaker reported on the current thirty-one
Community and Migrant Health Centers in the border region reflecting a $70 million investment. Since the start of the Presidential Initiative, the border region has been awarded 14 new Access Point Grants meaning there are 14 new clinics, new health care facilities providing care to people who otherwise would not have received it. In addition, twenty existing CHCs expanded their hours and staffing through expanded Medical Capacity Grants, adding the capacity to address oral health, mental health, substance abuse, and delivery of drugs. In total, forty-five new grants representing $17 million of new support has gone to the border since the start of the Presidential Initiative.

**Carolina Gomez**  
*Mexico Ministry of Health*

Ms. Gomez described Seguro Popular (Popular Insurance). With political and financial support, 29 states of the Republic, including northern Border States, now participate in Seguro Popular. There is evidence that on an annual basis, 2-3 million Mexican families invest a portion of their income for medical attention and that the catastrophic expenses that many families have leads to injustice and greater inequality. Seguro Popular isn’t a program, it’s a public financing instrument that allows healthcare services to achieve a universal coverage goal of protecting those that aren’t covered by the Social Security system. It’s a voluntary health insurance program not affiliated with the other government services (i.e. IMMS or ISSTE).

There are seven services covered by Salud Popular including 91 interventions. It covers 85% of the most common health services provided by public health centers and 70% of the services provided by hospitals. It is supported with federal and local government resources and by client fees (cuotas). The initial cuota begins at $640 (pesos) and goes up to $6,300 (pesos/year). Through the third trimester of this past year, 1.1 million families (4.5 million individuals) have joined Seguro Popular. Forty percent of enrollees are from rural areas and 94% are among the poorest economic groups; 7-of-10 families are headed by women. We have authorized 2 million consults and 7,600 emergency cases in the entire country; 4,900 people have become hospital inpatients. Currently, Seguro Popular operates in 117 general hospitals and 2,469 clinics nationwide.

**Bi-national Approaches to Border Health Policy**

**Lic. Hilda Davila Chavez**  
*Assistant Director General for Migrant Health  
Mexico Secretary of Health*

Lic. Dávila Chávez reported that 26.6 million persons of Mexican decent live in the U.S. and, among them, 9.8 million were born in México. This comprises the largest national-origin group in the country. The U.S.-México border is the most dynamic border in the world and it has, within the context of rising globalization, populations that are highly vulnerable. Migrant populations present challenges to both governments because they don’t necessarily fit into health service systems that are fixed and stable. Migrant laborer families who remain in México are frequently left without any financial protection; they also face interruptions and delays for treatment such as tuberculosis, reproductive health, or other health services. In México, 18 million people migrate internally following México’s agricultural seasons. Migrants present a particular challenge in the north as
well in the south, along the border with Guatemala. One program organized to address migrant worker needs is called “Leave Healthy, Return Healthy”. In this program, health as an individual responsibility is emphasized through self-care instruction and on transitional aspects, whether migrants are traveling within México or to the U.S. Ms. Dávila Chávez spoke about the success México has had with vaccination coverage associated with national immunization day campaigns that have been expanded weeklong campaigns. She spoke about the importance of in a cooperative bi-national manner because many border residents remain marginalized and fearful about going to local health programs. She identified the Vantanillas de Salud program being organized to provide health education and health service information in México’s (U.S.) Consulates in Los Angeles, San Diego, Dallas y Chicago. Finally, Ms. Dávila Chávez spoke about the “Seguro Popular” health services offered to provide service to all Mexicans including those who travel from the exterior and for their families. It is hoped that the Mexicans living outside the country will be able to purchase “Popular Insurance” in the U.S. to protect their families in México.

Eva Moya, MSW  
*Executive Director, U.S. Section*  
*US-México Border Health Commission*

Ms. Moya spoke about the U.S.-México Border Health Commission and summarized four priority recommendation areas that include: Increase access to preventive services for the people living in border communities; Improve health education, primarily disease prevention and control; Improve the health workforce; and Improve public health infrastructure that helps both countries respond to terrorism or threats of an infectious event. Ms. Moya discussed Commission progress including the many activities associated with the Border Bi-national health week. She asked for support of Commission efforts to encourage health professional (bi-national, bilateral, multi-institutional) cross-training, to disseminate information guides concerning the Border Models of Excellence program, to expand the use of tuberculosis bi-national information card model to better share healthcare information in such areas as HIV/AIDS or immunization programs; and, to the Mexican government, to continue to increase their commitment and leverage resources to promote Seguro Popular; and to coordinate activities of the Early Warning Infectious Disease Project (EWIDS) which offers a model framework for international collaboration around infectious disease surveillance, management, and reporting.

The Honorable Eliot Shapleigh  
*Texas State Senate, Border Legislative Conference*

Texas State Senator Shapleigh spoke about the Border Legislative Conference, which includes representatives from each of the 10-border state legislative bodies. The BLC includes a Health Committee which has, currently, the following priorities: (1) Access, (2) Prescription drugs and access to those drugs, and (3) Substance abuse. Senator Shapleigh identified a series of program ideas as border health models including: an international air emissions trading credit, the Border Health Corps, a cross-border multi-disciplinary training rotation, and a school-based exercise program. Finally, he emphasized that border health professionals can solve complicated problems with a “Can-Do” spirit, by sharing ideas that work now and developing new ideas together.
The Honorable Luís Alberto Cáñez Lizárraga
Sonora State Legislature
Chair, Health Table, Border Legislative Conference

Dip. Cáñez Lizárraga spoke about the Border Legislative Conference (BLC) meeting organized in Santa Fe, New México on July 8-9, 2004. State legislators from both sides of the border attended this event to discuss major themes of importance to both countries. Dr. Cáñez Lizárraga, Co-Chair of the BLC Health Table, has participated for more than 16-years with the U.S.-México Border Health Association (USMBHA) and has worked on programs such as “10-for-Tuberculosis”. He noted a great deal of communication among epidemiology offices in monitoring and coordinating patient care for patients who cross the border. These efforts have shown some excellent results. Dr. Cáñez Lizárraga emphasized that the BLC Health Committee is committed to forging close relationships among legislators and health professionals from both sides of the border but that adequate tools are required including the necessary budget. He noted that while much has been accomplished, there is still a great deal lefty to be done. Rep. Cáñez Lizárraga promised to call the Health Committee together again in Hermosillo, on November 18-19, 2004.

Daniel Gutierrez, MD, MPH
Chief, U.S.-México Border Field Office
Pan American Health Organization

Dr. Gutiérrez introduced the Pan American Health Organization, a member agency of the United Nations and the World Health Organization, with association in 34 countries throughout the Western Hemisphere. PAHO was founded in 1902 and became part of the United Nations in 1948. PAHO offices work with the Ministers of Health in each country including the Secretary of Health in the United States (Mr. Tommy Thompson) and in México (Dr. Julio Frenk). Dr. Gutierrez recognized the significance of the creation of the U.S.-México Border Health Commission, which has representation from the federal, state, and local governments. He stated that the Commission has taken some very important steps including the Healthy Border 2010 Plan. He suggested the need for greater policy “harmonization” because border health problems must be considered within a bi-national context. Dr. Gutierrez emphasized that a variety of injustices and inequalities exist along the border leading to many health disparities. Different communities are vulnerable, especially migrant and indigenous populations who experience special challenges in gaining access to health care. Specific health problems include unwanted pregnancies, adolescent suicide, and accidental injury associated with automobile crashes. Dr. Gutierrez mentioned the importance of developing strategic alliances and associations to develop health, environmental, education, and commerce initiatives. Also, he indicated that technical exchanges are necessary through shared academic training programs with support from government and private foundations.
R.J. Dutton, PhD  
 *Director, Office of Border Health, Texas Department of Health Services  
 Border Governor’s Conference-Co-Chair, Health Table*

Dr. Dutton described the functions and organization of the U.S.-México Border Governor’s Health Table, whose members meet as part of the annual Border Governors meeting that has been organized during the past 22-years. Topics addressed by the Border Governor’s Conference include agriculture, border crossings, border security, economic development, education, energy, environment, health and tourism. Representatives of the Health Table include the ten U.S.-México border state health officers; meetings alternate back-and-forth between the U.S. and México. Health Table members work to develop resolutions for the states to work on jointly, which are then announced at the Annual Meeting the following year. This agenda-setting process takes months as it requires agreement among members from all ten states. Dr. Dutton suggested the need for better coordination and improved communication among the different umbrella groups that support policy initiatives. Agencies should come together, identify resources, and then work together in a strategic manner based on a unified approach to border health policy. It’s important to work locally but think regionally to develop a strategic approach that addresses border needs and realities while, at the same time, enabling professionals to move across national, federal, state, and local policy levels.

### Pharmacy Services and Products

*Howard Eng, MS-DrPH  
 *Director, Southwest Border Rural Health Research Center  
 University of Arizona, Mel and Enid College of Public Health*

Dr. Eng presented information concerning the importation of pharmacy products across the border. He listed several concerns including environmental storage in Mexican facilities that do not have air-conditioning as excessively high room temperatures can degrade medication stability. He also identified concerns with therapeutic equivalence, when medications are manufactured through different processes leading to different dosage forms. Dr. Eng believes that when a person crosses the border to purchase medication, they should be informed whether it is the same strength in both countries. (It was estimated that about 20 medications have different therapeutic equivalencies). If the dosage levels are different, people may be getting too much, or too little of the medication’s active ingredient. This is most important when the therapeutic range between toxic and therapeutic levels is narrow. Another potential problem area identified includes package insert information that uses a language the consumer may not understand. Dr. Eng reported that the FDA has disseminated guidelines for people who travel to other countries to purchase medication however, he concluded that more information should be available to inform consumers about associated risk.
Ing. Maribel Prospero Cobos
Jefa del Departamento de Insumos para la Salud
de la Subdirección de Regulación y Fomento Sanitario
Servicios de Salud de Chihuahua

Ing. Prospero Cobos provided an overview about how health programs in México and in the State of Chihuahua are regulated. She began by describing the Ministry of Health’s responsibility for insuring access to healthcare services for all, as stipulated in Article 4 of the Mexican Constitution. In 2001, a Federal Commission Federal Commission for Protection against Sanitary Risk (COFEPRIS) was authorized as a decentralized agency within the Secretary of Health. COFEPRIS has since negotiated agreements with each state to carry out its mission to control, regulate, and promote sanitary conditions. In these agreements, sanitation procedures and regulations are made clear. Federal and state governments work together to rectify problems and complaints. One area of regulation involves the control of pharmacies (farmacias, boticas, drogerías). A distinction is made whether the business does or does not distribute narcotics or psychotropic medications. Businesses that do not distribute narcotics or psychotropics are referred to as farmacias or drug stores. Pharmacy boutiques or drug stores with the appropriate license are able to sell psychotropic medication, vaccine, toxins, anti-toxins from animals. Prescription of psychotropic medications requires special formulary audit procedures and is tightly regulated. A prescription is required to sell any psychotropic medication however Ing. Prospero Cobos recognized that the details and origin of the prescription is still unclear. She mentioned the requirements for importation and exportation pharmacy products and she discussed training requirements for pharmacy service personnel.

Border Health Services

David Warner, PhD
Professor, University of Texas at Austin

Rachael Maguire
University of Texas at Austin

Kelly Shanahan
University of Texas at Austin

Dr. Warner, Ms. Shanahan and Ms. McGuire presented findings from a Study on cross-border health insurance plans carried out among Plans in California and describing regulatory impediments in Texas. Ms. McGuire reported that bi-national insurance services are generally organized into four categories: (1) Single Network Plans, with a physician network available on only one side of the border. (2) Dual Network Plans, where physician networks are available on both sides of the border. (3) Self-Funded (ERISA) Plans, usually offered by employers who provide services as employee benefits. (4) Latino-oriented plans, insurance products specifically designed for, and marketed to Latino populations in the United States (although these do not necessarily provide cross-border coverage).
Bi-national health insurance began in California in 2000 when SIMNSA, a Mexican Plan, along with Access Baja of Blue Shield, became regulated to sell insurance services. The current requirements for cross-border HMO products in California are: (1) Be licensed by the California Department of Managed Health Care; (2) Meet financial standards; (3) Be sold to employers at group rates through brokers, agents, and third parties; and (4) Provide emergency care and urgent care in the United States. Ms. Shanahan described the ERISA Plans as self-funded and regulated by the federal government, not by state insurance departments.

Western Growers, began operating in the 1950’s as an ERISA plan and currently covers more than 100,000 lives. Dr. Warner summarized the portion of the Study completed in Texas. He reported that the biggest issue keeping companies from developing cross-border services concerns the definition of “provider”. In Texas, health insurance plans have to be licensed by the State Board of Medical Examiners and, of course, this requirement doesn’t apply to most Mexican physicians. In California, SIMNSA is only supposed to be insuring Mexican citizens and their dependants. The Blue Shield Plan has been able to offer bi-national products as long as it was part of a dual choice option where people could choose the Mexican Plan and it would be less expensive but they also have the choice of a standard plan on the US side.

**Rudy Valenzuela, MSN, RN, FNP-C**  
*Director of Clinical Services and Health Promotion*  
*Regional Center for Border Health*

Mr. Valenzuela introduced the Regional Center for Border Health (RCBH) and described the CAPAZ medical discount network, which operates in South Yuma County, Arizona to increase the availability and accessibility of health care and community services. The RCBH targets the low-income uninsured population that falls between the 100-400% federal poverty level. They begin at 100% FPL because Arizona’s Medicaid Program (AHCCCS) insures qualified residents up to 100% FPL.

Mr. Valenzuela offered several examples of how the discount network functions including the Complete Blood Count (CBC) which, in the United States, costs the consumer $21. The Medicare-allowable cost is $8. In México, a CBC costs $5.50 and, with a discount, the CAPAZ-Mex enrollee can buy it for $4.40. So, a patient who is part of the CAPAZ Discount Network has the choice to obtain the CBC in the U.S. or go to México to receive the discount. There is a price differential of about $17. For someone who comes to the Regional Center for Border Health, where Mr. Valenzuela is the primary care provider, the initial visit cost is $125. The same service from the discount network in México is $10. If they were a member of the CAPAZ Network, the cost to see a provider at the RCBH would be $75 (a discount of $50). Another example is a patient who needs an appendectomy. At the Yuma Hospital, the cost would be $12,000. With the CAPAZ discount, it would be $4,252 and in México, the cost for a CAPAZ-Mex enrollee for an appendectomy is $210.

Cost is an important motivating factor however many South County residents choose to cross the border for health care because of language and/or service preferences. The
CAPAZ Medical Discount Network was initially organized with support from the Healthy Community Access Program (HCAP) but federal funding ended in December 2004. The RCBH staff are looking at longer-term sustainability and need to recruit about 3000 members to remain sustainable. Right now, sustainability depends on in-kind support provided by the Regional Center for Border Health.

**Dr. Elmyra Ybañez**  
*Colegio de la Frontera*  
Dr. Zepeda described a collaborative research study being organized by UCLA and COLEF. The overall research objective is to evaluate how trans-border relationships that influence the health of seniors living in the border region. The research will help evaluate how health and healthcare access is managed through trans-border relationships with particular interest in health care provided in the home. Research questions include: How do household health support networks function? What are family strategies for seeking health services? How does the household react to poor health? Who took care of the person who was sick and where did the resources come from? How to border residents gain access to, and use health services in México and in the United States? What is the existing population health status? And, how do people manage language differences, immigration, employment and available income? Immigration is a very important factor in the research. The Study relates to previous studies conducted by the Colegio de la Frontera Norte, which has twenty-one years of experience studying trans-border relationships.

**Center of Excellence Consortium Meeting**

**Martha Medrano, MD, MPH**  
*Director, Medical Hispanic Center of Excellence*  
*University of Texas Health Sciences Center, San Antonio*  
Dr. Martha Medrano conducted a meeting for those involved with the U.S.-México Border Center of Excellence Consortium, Phase II Project. Major partners include the US-México Border Commission, the National Hispanic Medical Association, the Border Health Office, the HRSA Regional Office, the Texas Department of Health, and HRSA Programs (AHEC, HETC and research institutions). The Goals of the Center of Excellence are to: (1) Define the extent of health service research shortages in the border region; (2) Identify barriers to achieve research parity with the rest of the region and nation; (3) Develop cooperative strategies that will improve the shortage of researchers; and (4) Develop a long-term plan to implement state and regional strategies.
II. Recommendations

**IN RECOGNITION THAT** good neighbor relations between the United States and Mexico are of the highest importance given our close proximity and the increasing economic, social, and cultural exchanges, and that:

- Increasing access to healthcare was emphasized as a health policy goal by the Secretary’s of Health in both countries during the 2004 Border Bi-national Health Week; and

- Health is a value shared in both countries, however health care systems are organized differently, health professionals are trained differently, and technology, services, and products are poorly distributed within each country and across regions; and

- Economic, legal, cultural, and technical barriers challenge border residents in gaining access to health care services; and

- Progress is being made in the development of border health policy and coordinated program models that have improved access to healthcare; and

- The U.S.-Mexico border region offers a unique opportunity to innovate by organizing a health care system that enables practitioners to deliver services to those who choose to receive health care.

**BE IT THEREFORE RESOLVED** that the U.S.-Mexico Border Health Commission, in cooperation with border partner agencies including the Pan American Health Organization, local universities, medical providers, and federal partners work together to:

1. Organize a U.S.-Mexico border site visit for legislators and staff members to visit the border and get to know first-hand about the challenges and opportunities of delivering health care in a bi-national region.

2. Organize an educational summit on border health for Congressional members and staffers in the nation’s capitals.

3. Call upon the U.S. Surgeon General to publish a Report that documents border community health status, establishes measurable baselines for priority problems, and outlines future health policy directions.

4. Request that the Mexican Secretary of Health complete a feasibility assessment to enable access to Seguro Popular for Mexican citizens living in the exterior.
5. Disseminate a (border-wide and bi-national) catalog of health professional training opportunities that provides certification and encourages cross-training, offering exposure to the other country’s health care system for students and professionals.

6. Speed development of bi-national disease reporting systems, replicating the lessons learned from the tuberculosis control model system to maternal health, immunization, and HIV/AIDS treatment and control.

7. Call upon the U.S. Center for Medicare and Medicaid Services (CMS) to organize training and support services that encourages border hospitals to pursue reimbursement for emergency care provided to undocumented people.

8. Call upon HRSA’s Office of Rural Health Policy to replicate the Rural Assistance Center expanding services to border health professionals and to provide resources to seed and test service models, such as a border community Ombudsman Program.

9. Call upon the Food and Drug Administration to work with Mexican counterparts to create a bi-national agreement that enables officials from both countries to share pharmacy product information that enables the determination of therapeutic equivalence.

10. Call upon the Food and Drug Administration to work with border researchers to evaluate and document pharmacy product quality and disseminate information that educates the public concerning any risk associated with crossing the border to purchase pharmacy products.

11. Call upon technical experts from the Pan American Health Organization to help assess the capability of U.S.-Mexico border local communities to perform essential public health services and functions.

12. Support emerging border health coalitions (i.e. border state medical associations, border hospitals, etc.) through the annual production and dissemination of a Border Health Directory to include coalitions, medical providers, public health and advocacy groups including federal, state, and local listings.
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