Mexican Immigrants' Access to Healthcare On the U.S.-Mexican Border

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Joshua Roberts/Reuters

Migration and healthcare coverage are two very serious problems, even more so when they are intertwined, mutually fostering their disadvantages. The United States is the destination of almost 90 percent of the world's migrant population,[1] and Mexico, as its neighbor and due to its economic and social crisis, is the country that contributes the largest number. In 2010 alone, it ranked first for the number of international migrants, expelling 1.19 million people, adding to the little over 33 million individuals of Mexican descent already living in the United States, of whom 21.2 million were born there. Today, Mexicans represent 4 percent of the country's total population and about 30 percent of all immigrants.[2]

Immigrants face a series of obstacles and difficulties and see their rights trampled upon. One of those rights is the right to health. So, it is fundamental that people understand and take on board the fact that this right is recognized by different national and international instruments.[3] This article describes very briefly the Mexican and U.S. systems and analyzes the changes brought about by the healthcare system reform sponsored by Barack Obama. We also map the actors involved, giving examples of some national and binational, governmental and non-governmental initiatives that have been put in place to improve the health of immigrants along the border.

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The Mexican and U.S. Healthcare Systems

Mexico's healthcare system is both public and private. The public sector offers coverage to part of the population through social security linked to formal employment through the Mexican Social Security Institute (IMSS); the Institute for Social Services and Security for Government Workers (ISSSTE); Mexico's state-owned oil company, Petróleos Mexicanos (Pemex); the Ministry of Defense (Sedena); and the Ministry of the Navy (Semar). The rest of the public sector focuses on the general public, mainly low-income individuals through the Ministry of Health (SS), State Health Services (Sesa), the IMSS-Opportunities Program (IMSS-O), and Popular Health Insurance (SPS).

The private health sector is made up of insurance companies and private service providers. Currently, the system is facing several problems given that the state has not been able to guarantee minimum services for all. Services are not distributed geographically according to the need for care; problems of access, equity, and quality exist; resources are not rationalized or optimized; and there is a persistent lack of resources to resolve priority health problems.[4]

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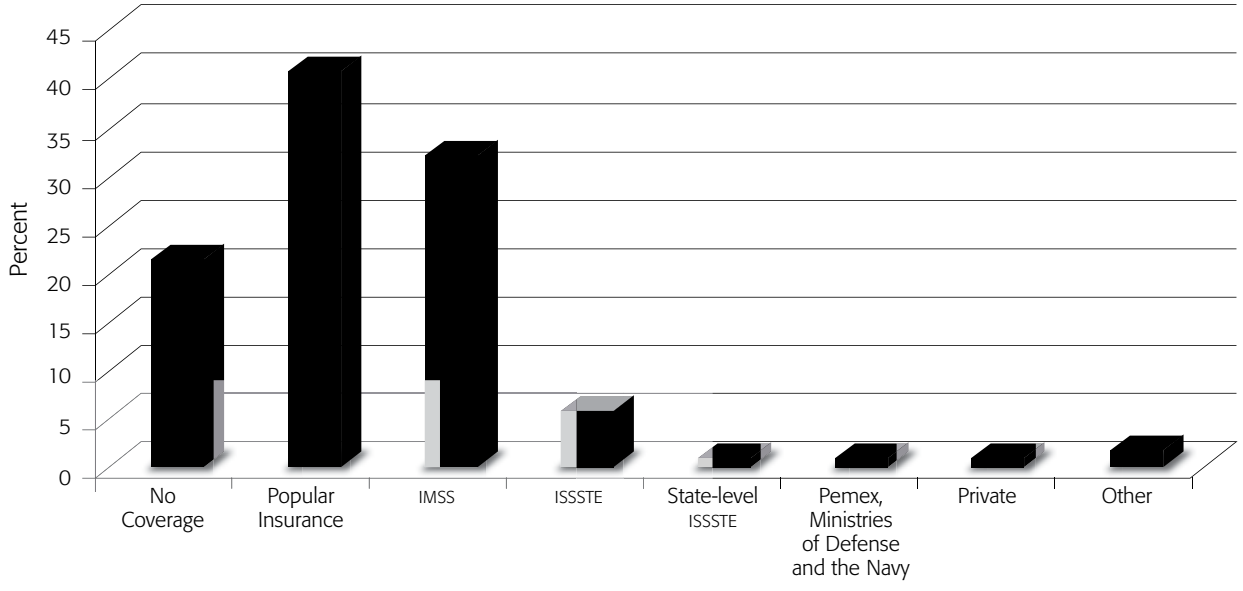
Also, since the Popular Health Insurance program was initiated in 2004, the number of people affiliated has increased every year without achieving the hoped-for universal coverage by the target year, 2010. There is also a discrepancy in the data with regard to the affiliation of the 17 million people reported by the 2010 census and the National Commission for the Protection of Health.[5] Graph 1 illustrates the affiliation to health services in Mexico. The enormous gap between the public and private sectors should be underlined.

The U.S. health system is mixed: public and private, state and federal. It operates mostly through the purchase of private insurance policies, which can be paid for by employers or acquired directly by U.S. citizens or their spouses. The commercial logic of private insurance policies does not differ

Graph 1
Health Care Coverage in Mexico (2012)



Source: Developed by the authors using estimates from Coneval based on MCS-ENIGH, "Indicadores de acceso y uso efectivo de los servicios de salud de afiliados al Seguro Popular," 2012, p. 20, http://www.coneval.gob.mx/Informes/Evaluacion/Impacto/Acceso%20y%20Uso%20Efectivo.pdf, accessed February 12, 2015.
Note: An individual can be affiliated to more than one institution.

at all from that of other kinds of goods or services. With regard to public insurance schemes,[6] one is Tricare, designed for those in the military and managed by the Defense Health Agency.[7] There are two other federal programs: Medicare, which covers citizens over the age of 65 and people with disabilities or severe health problems like cancer,[8] and Medicaid, which is for low-income families, children, pregnant women, adults without children, older adults, and persons with disabilities. Each state of the union has its own Medicaid program.[9]

The Veteran's Health Administration (VA) is a public insurance system for combat veterans, which offers care in hospitals, clinics, community centers, and the home, among other services.[10] Finally, another public insurance scheme is the Children's Health Insurance Program (CHIP), which provides coverage to about 8 million children and families whose incomes are too high to qualify for Medicaid, but who cannot pay for private insurance.[11]

Table 1 illustrates the percentage of coverage in 2013 by these insurance plans, showing that none of the programs surpasses 12.5 percent, a very low figure. It was in response to this that Barack Obama decided to carry out a reform of public health services so that they would be more affordable and cover more people, what has been called "ObamaCare."

TABLE 1
HEALTH INSURANCE IN THE UNITED STATES
ESTIMATES FOR 2013 (PERCENT)

Health Insurance Coverage	12.5%
Private Health Insurance	11.8%
Employer-based Health Insurance	9.1%
Direct-purchase Health Insurance	9.8%
Tricare/Military Health Coverage	10.9%
Public Coverage	11.9%
Medicare Coverage	8.1%
Medicaid/Means-Tested Public Coverage	10.6%
VA Health Care	10.8%

Source: U.S. Census Bureau, *American Community Survey, Health Insurance Coverage Status,* 2013, http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_13_1YRS2701&prodType=table, accessed February 20, 2015.

OBAMACARE

Health coverage in the United States is low even for citizens and financially unaffordable for the vast majority since it is mainly provided by the private sector. Another disadvantage is that it is conditioned on formal employment, a difficult condition since many employers do not offer medical insurance and a high percentage of immigrants are undocumented. In addition, these forms of insurance are selective, making coverage limited. Of all the immigrants in the United States, the most unprotected in terms of health care are those of Mexican origin. According to figures reported, 53.5 percent have no coverage; the figure is higher (63 percent) among those who have lived there for less than 10 years. In addition, of the 46 percent who do have some coverage, 27 percent have private insurance, which means that those with lower incomes are less likely to have medical insurance. In short, approximately 6.4 million Mexican immigrants in the United States have no health insurance.[12]

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Given these problems, Obama fostered the Patient Protection and Affordable Care Act (PPACA), also known as the Affordable Care Act (ACA), healthcare reform, or simply ObamaCare, which he signed into law on March 23, 2010. Its aims are to increase the quality and affordability of health insurance plans, decrease the number of people without insurance by expanding public and private coverage, and reduce the costs of access to health care, both for people and for the government.

ObamaCare has allowed the public to purchase health insurance by registering on line, a process open in different periods from its initial launch. The last period lasted from November 15, 2014 to February 15, 2015.[13] ObamaCare targets those who are not covered by their employers or do not qualify for any government health insurance program, or are on the list of exceptions. However, it does not cover everyone: undocumented immigrants cannot access health insurance and "a person who is not a citizen of the United States" cannot benefit from the ACA.[14]

According to Óscar Chacón, to purchase ObamaCare, you have to have a social security number. Before the reform, private insurance was an option for undocumented immigrants. Another problem Chacón pinpointed is that immigrants who could access ObamaCare have not had many incentives to do so since Mexican and Central American immigrants consider health a privilege, not a right. He has also pointed out that the higher immigrants' educational levels, the greater awareness they have that health is a right.[15]

Unequal Access to Health for Immigrants

Today, no public policy for binational health insurance exists, which means that Mexican immigrants in the United States receive their care from the U.S. health system as long as they are not undocumented. Therefore, their migratory status determines their ability to access public or private health services.

Improving Mexican Immigrants' Health in U.S. Border States

Along the Mexico-U.S. border, a series of different actors, governmental and non-governmental, state and federal, on both sides of the border come together to provide care for Mexican immigrants. Binational and public/private mixed initiatives also exist. Despite all these efforts, health care does not reach everyone, particularly the undocumented.

The Mexican government has implemented different activities and programs for Mexicans residing in the United States through the Institute of Mexicans Abroad (IME), such as the Binational Health Week, the Health Windows, Repatriation of Gravely Ill Compatriots, Go and Come Back Healthy, and Promoting Health on the Northern Border programs.

The Health Windows program was created by the Mexican government in 2002, and developed by the Ministries of Health and Foreign Relations through the Institute of Mexicans Abroad. It offers information and facilitates access to local health services, focusing on immigrants who have no access to health care. One of these windows exists at each consulate (50 in all throughout the United States), and two windows are mobile. They operate with the inter-institutional collaboration of Mexico's Health Ministry, local agencies, the Centers for Disease and Control Prevention (CDC), the National Institute for Occupational Safety and Health (NIOSH), the Health Resources and Services Administration (HRSA), and the American Cancer Society.[16] Although the program is quite broad because it operates in all the consulates, many immigrants of Mexican origin reside far away from them.

The Binational Health Week organizes health promotion and preventive activities for immigrants and their families, in collaboration with the Health Initiative of the Americas.

The Repatriation of Gravely Ill Compatriots program seeks to channel these patients to a federal or state health center according to the illness they have been diagnosed with.[17] The Binational Health Week organizes health promotion and preventive activities for immigrants and their families, in collaboration with the Health Initiative of the Americas and with the participation of different bodies from both countries.[18]

The Go and Come Back Healthy program carries out health promotional and preventive activities in places of origin, transit, and destinations of immigrants and their families through inter-institutional and inter-sectoral participation. The Promoting Health on the Northern Border program does just that by concentrating on priority issues among the border immigrant population in the cities that do not have Mexican consulates.[19]

The US-Mexico Border Health Commission (BHC) is a binational body whose objective is to optimize health and quality of life for inhabitants of the border area. It is comprised of the respective federal health ministry and department, the chief health officers in the 10 border states, and outstanding health professionals from both countries. Its priorities are access to health, strategic planning, research, data collection, and academic alliances, tuberculosis, obesity, diabetes, infectious diseases and public health emergencies. In 2013 and 2014, some of their activities included Leaders across Borders; the U.S.-Mexico Border Reproductive Health Summit; the U.S.-Mexico Border Tuberculosis Consortium; the U.S.-Mexico Border Binational Infectious Disease Conference; the Border Health Symposium; the Power of Collaboration, Community-based Healthy Border Initiatives; the Prevention and Health Promotion among Vulnerable Populations Initiative; the Border Obesity Prevention Technical Work Group Meeting; Healthy Border 2010/2020 Strategic Plan: Phase V; the

U.S.-Mexico Border Health Research Work Group Meeting; and the Annual Binational Border Health Week.[20]

Some examples of civil society organizations' activities along the border should be mentioned. Prevencasa is a civic association based in Tijuana that works on prevention of HIV/AIDS and other sexually transmitted diseases. It arose out of the collaboration between two professors at the University of California, San Diego School of Medicine and a Mexican doctor who continues heading the organization. Most of the research is funded by the United States.[21]

The US-Mexico Border Philanthropy Partnership (BPP) is a foundation that supports a binational network of organizations working on the border. BPP published a report in 2006, "Corporate Giving Trends in the U.S.-Mexico Border," presenting the results of a survey of 110 companies. Of all the goals of their actions, 13 percent involved health. Another example is the Binational Health Collaboration Program implemented by the United States-Mexico Foundation for Science (Fumec). Fumec acts as a fiduciary agent to allocate funds, coordinate health activities, manage technical and administrative aspects of the institutions involved, and link up actors in academic and institutional networks.[22]

Despite the multiplicity of actors involved in the U.S. and Mexican health systems, in both countries, health continues to be a privilege reserved for those with a higher socio-economic level or who belong to specific social groups.

Conclusions

The U.S. and Mexican health systems are divided into public and private. In the United States, a greater percentage of the care is private. In Mexico, although the Popular Insurance program has increased coverage in recent years, it is still a long way from providing care for all.

Initiatives by both governments have been important but insufficient to cover the health needs of the immigrant population. Their impacts have been limited because they have focused mainly on promoting health, but not in providing care. Other actors have emerged who have intervened in the issue, covering some deficiencies; these are the non-governmental organizations and civic and social associations that have not discriminated against the undocumented when providing care.

ObamaCare does not cover everyone: undocumented immigrants cannot access health insurance and "a person who is not a citizen of the United States" cannot benefit from the Affordable Care Act (ACA).

Thus, the lack of coverage of the immigrant population's health needs continues to be a very serious problem; despite what has been established in law, neither the Mexican nor the U.S. governments have achieved universal coverage or real access for all, which is aggravated in the case of immigrants, particularly the undocumented. This has contributed to health not being perceived as a right and to people not understanding that it is legally and legitimately something that can be demanded and not a privilege or charity. VM

Notes

[1] Fundación BBVA Bancomer, A. C., "Anuario de migración y remesas," Mexico, 2013, https://www.bbvaresearch.com/KETD/fbin/mult/1212_AnuarioMigracionMexico_2013_tcm346-363287.pdf, accessed February 12, 2015.

[2] Consejo Nacional de Población (Conapo), "Índices de intensidad migratoria Mexico-Estados Unidos 2010," http://www.conapo.gob.mx/work/models/Conapo/intensidad_migratoria/pdf/Migracion_Mex_EU.pdf, accessed February 12, 2015.

[3] Among them, the Universal Declaration of Human Rights and the International Covenant on Economic, Social, and Cultural Rights, which stipulate that states have the obligation to respect the right to health, refraining from denying or limiting equal access for all persons, whether for economic, physical, or cultural reasons, to preventive, curative, and palliative care. World Health Organization, "Migración internacional, salud y derechos humanos," December 2003, http://www.who.int/hhr/activities/2005%20PRT%2016325%20ADD%201%20Migr_HHR-Spanish%20edition.pdf, accessed February 12, 2015.

[4] M. López, L. Durán, and M. Villanueva, "La necesidad de transformar el sistema de salud en Mexico," *Gaceta médica de Mexico* vol. 147, 2011, p. 472.

[5] A. Laurell, "Impacto del Seguro Popular en el sistema de salud mexicano," Buenos Aires, Consejo Latinoamericano de Ciencias Sociales (Clacso), 2013, http://www.facmed.unam.mx/deptos/salud/sesionesacad/asacristina/ImpactodelSeguroPopular.pdf, accessed February 12, 2015.

[6] The public programs offer coverage to low-income individuals but have detailed eligibility criteria linked to income levels, migratory status, and a minimum period of legal residence. See P. Leite and X. Castañeda, "Mexicanos en Estados Unidos: (falta de) acceso a la salud. La situación demográfica en Mexico," 2008, p. 117, http://www.portal.conapo.gob.mx/publicaciones/sdm/sdm2008/08.pdf, accessed February 12, 2015.

[7] Tricare, 2015, February 20, 2015, http://www.tricare.mil/About.aspx.

[8] Medicare, 2015, February 20, 2015, http://www.medicare.gov/.

[9] Medicaid, 2015, February 20, 2015, http://medicaid.gov/.

[10] Veteran's Health Administration,2015, February 20, 2015, http://www.va.gov/health/.

[11] Children's Health Insurance Program (CHIP), 2015, February 20, 2015, https://www.healthcare.gov/medicaid-chip/childrens-health-insurance-program/.

[12] Secretaría de Gobernación/Consejo Nacional de Población (Conapo), "Migración y salud. Inmigrantes mexicanos en Estados Unidos," October 2013, http://www.conapo.gob.mx/es/Conapo/Migracion_y_Salud_Inmigrantes_Mexicanos_en_Estados_Unidos, accessed February 12, 2015.

[13] ObamaCare Facts, "ObamaCare Facts: Facts on the Affordable Care Act," 2015, http://obamacarefacts.com/obamacare-facts/, accessed February 20, 2015.

[14] Obamacare.net, "Obamacare Explained," October 10, 2014, https://obamacare.net/obamacare-explained/?on=OCF-wp-listlink, accessed February 20, 2015.

[15] Interview by the authors with Óscar Chacón, the executive director of the National Alliance of Latin American and Caribbean Communities (NALACC), in Mexico City, October 7, 2015.

[16] Mexico's Secretaría de Salud, Instituto de los Mexicanos en el Exterior, and Secretaría de Relaciones Exteriores, "Ventanilla de Salud," 2015, http://ventanillas.org/index.php/en/, accessed February 20, 2015.

[17] PRI, Secretaría de Asuntos Migratorios, "Repatriación de connacionales enfermos graves a Mexico," 2014, http://www.migrantes.pri.org.mx/Articulos/Articulo.aspx?y=2196, accessed February 12, 2015.

[18] Semana Binacional de Salud, October 4-18, 2014, http://www.semanabinacionaldesalud.org/, accessed February 12, 2015.

[19] Eduardo Jaramillo Navarrete, "Estrategia integral de atención a la salud del migrante del gobierno mexicano," 2010, University of California at Davis, agcenter.ucdavis.edu/migration/presentations/12_Jaramillo_Eduardo.ppt, accessed February 12, 2015.

[20] Border Health Commission, 2015, "Strategic Priorities," http://www.borderhealth.org/bhc_initiatives.php, accessed February 20, 2015.

[21] USAID/AIDSTAR-One, "HIV Prevention on the U.S.-Mexico Border Addressing the Needs of Most-at-Risk Populations," Prevencasa, July 2010, p. 3, http://www.aidstar-one.com/sites/default/files/US-Mexico%20Border%20Case%20Study.pdf, accessed February 20, 2015.

[22] Valeria Marina Valle, "Private Sector Activities to Reach Millennium Development Goal Six on the U.S.-Mexico Border," *Voices of Mexico* no. 98, Autumn-Winter, 2014-2015, Mexico City, pp. 100-101.