

Appendix H

Brief: Consulate Clinic

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Findings

Although there appears to be no legal prohibition stateside to creating a clinic within the boundaries of a Mexican consulate, there are nevertheless several obstacles and issues which would need to be addressed. Mexican Consulate policy states:

The Consulate never asks if an immigrant is legal or not. The Consulate only asks if they are legal. The party must prove that they are Mexican before services are offered. It is against International Law (Geneva Convention) for the Mexican Consulate to offer services to anyone NOT Mexican. The Consulate can provide an Identification Card to proven Mexicans ...The Mexican Consulate can not provide services of healthcare for the growing Mexican population in Colorado (503,518). Healthcare issues are handled by local agencies/governments .

If a consulate clinic could be established, services would be limited to Mexican citizens. In essence, healthcare for Mexican nationals would remain on Mexican soil. This would also open the door for requesting greater responsibility on the part of the Mexican government in regard to healthcare cost. This may help to explain the last clause cited: "The Mexican consulate cannot provide services of healthcare for the growing Mexican population." Since there appears to be no legal restriction for providing health services it may be the case that the resources may simply not be available. Another issue to consider is the likely political response this may encourage. Joe Guzzardi, in an article entitled *Veterans Lose, Illegal Aliens Win - Illegal Aliens: The Health Cost Dimension*, states:

On January 17th, Secretary of Veteran Affairs Anthony J. Principi stated that VA health care enrollment for Category 8 veterans would be suspended for one year. (A Category 8 veteran is one who does not have a service-connected disability and has an income in excess of \$13,000.). ..There is something terribly wrong with this picture. The Mexican Consulate provides free legal advice on how their citizens who reside here illegally can receive U.S. taxpayer-paid benefits and defend their rights to receive them -- I would much rather pay the healthcare costs of a fellow Veteran than a foreign citizen living here illegally.

Such a viewpoint fails to take into account the economic contribution of Mexican workers. Many have also voiced concern over Mexican women giving birth on U.S. soil, entitling their children to citizenship and services. In a roundtable discussion organized by the Humanitarian Accountability Project and the World Health Organization it was noted that a "companion policy document" to the Declaration of Geneva called the WMA International Code of Medical Ethics "demarcates a duty to give emergency care to patients which is considered binding unless other medical professionals are both willing and able to provide that care." It is not unlikely that documented and undocumented Mexican nationals may be refused emergency medical care if a consulate clinic in the area begins to provide those services. Although the opening of

consulate clinics, if established, may successfully provide needed healthcare to Mexican nationals, a more viable option may be to open clinics in conjunction with Mexican and/or Latin American medical schools. Partnerships with Mexican medical schools at or near the border may prove to be the most convenient and beneficial means to improve and provide healthcare to those in need.

Insufficiency

The Teague Grant Authorization Act, introduced into the House as H.R. 2126 found the following:

(1) A severe shortage in the number of physicians and other health care professionals in the United States is predicted for the next two decades, as a result of a substantial growth in demand for medical services compared with the number of medical school graduates, foreign doctors in the United States, and other health care professionals available to meet that demand.

The availability and cost of healthcare is an issue that concerns all persons living in the U.S., regardless of citizenship and origin. At the same time, there is a “continuing restrictive trend” in regards to issuance of National Interest Waivers (NIW) which enable foreign doctors to practice medicine in the U.S.. In “a precedent decision called” Matter of New York State Dept. of Transportation, Interim Decision No. 3363 (Acting Assoc. Comm’r, Programs, Aug. 7, 1998)(NYSDOT) eligibility requirements were set forth as follows:

(1) the person must be working in an area of “substantial intrinsic merit” (2) the proposed benefit must be “national in scope” and (3) “the petitioner seeking the waiver must persuasively demonstrate that he/she will serve the national interest to a substantial better degree than would an available U.S. worker having the same minimum qualifications.

The above three requirements are seen as sufficient justification for allowing foreign physicians to practice medicine in the U.S.. The provisions under law are insufficient to meet the growing need for affordable health care. Although the above requirements, cited from True Walsh and Milller, LLP, apply to doctors working in specific medical fields, including research, the requirements highlighted may serve to formulate effective arguments for foreign physicians wishing to work in clinics that meet the needs of the medically underserved. It is for this reason that the U.S. Mexico border may prove to be the ideal starting point.

Conditions

The first requirement in the “three part test for” NIW eligibility states that the “person must be working in an area of ‘substantial intrinsic merit.’ ” A report by The United States – Mexico Border Health Commission found the following:

- * Three of the 10 poorest counties in the United States are located in the border area
- * Twenty-one of the counties on the border have been designated as economically distressed areas
- * Approximately 432,000 people live in 1,200 colonias in Texas and New Mexico, which are unincorporated, semi-rural communities that are characterized by substandard housing and unsafe public drinking water or wastewater systems
- * The unemployment rate along the U.S. side of the Texas-Mexico border is 250-300% higher than in the rest of the country; and
- * Due to rapid industrialization, the communities on the Mexican side of the border have less access to basic water and sanitation services than the rest of the nation

In addition, the roundtable discussion on Medical Ethics and Humanitarian Work observed:

The mission to help those less fortunate is fundamental to the medical enterprise. Humanitarian interventions, however, typically occur in situations where the normal power dynamic between the care provider and patients is exaggerated.

Although, the above statement was made in reference to third-world countries where there exists instability and/or extreme poverty, the latter condition applies to no other region in or around the U.S. as it does to the U.S.-Mexico border region. Not only does the border region have the highest unemployment rate in the nation, but it is also the most uninsured region, with El Paso leading the way. Furthermore, in general, “the Mexican origin” population is overrepresented in low-wage jobs that neither offer insurance benefits or pay enough for the individual to afford insurance. In fact, overall, “Hispanic workers are less likely to get health benefits on the job, even if they are doing the same work as black or white employees.” Undocumented workers are even more susceptible to exploitation since avenues for legal redress are practically non-existent. To make matters worse, areas on the border are projected to lose funding for healthcare services. Economic hardship, low wages, lack of transportation, large areas with inadequate housing and basic services, a shortage of physicians, a lack of adequate health-services and funding are all disproportionately evident in the border region. The conditions for many more on the Mexican side of the border are certainly comparable to that of a third-world country. The article, *Texas Borderlands: Ground Zero of Health Issues* states:

Border residents cope with health issues that other Texans do not face. Sharing an international boundary ensures that disease, and other chronic illnesses will travel freely across this frontier, creating crises due to lack of physical infrastructure, inadequate access to resources and a poor health care infrastructure.

Infectious diseases that are unique to the Border cause serious health risks to residents. Multiple factors, including inadequate water and wastewater infrastructure, migration from Mexico, the movement of disease vectors across the Border... and inadequate disease surveillance contribute to higher rates of some infectious and chronic disease ... infectious diseases are not bound by borders ... Border residents deal with outbreaks of mosquito-borne dengue fever and west Nile virus, tuberculosis, hepatitis A and C, among others.

Cost and Integration

Not only are inadequate healthcare conditions evident to a substantially greater degree than in the rest of the country, but sharing a highly permeable international border with “inadequate disease surveillance” also raises issues of security. The primary goals of the US - Mexico Border Health Commission (USMBHC) “are to institutionalize a domestic focus on border health, which can transcend changes and create an effective venue for bi-national discussions to address public health issues and problems which affect the US-Mexico border populations.” The trend towards integration and the need to provide healthcare to Mexican nationals and others along the border is evident.

The availability of healthcare in Mexico is limited to individuals who actually hold jobs in Mexico. Persons who work in the U.S. are not eligible for healthcare services in Mexico through Seguro Social (Social Security). Furthermore there are few provisions for general welfare. Although a national boundary exists between Mexico and the United States, the USMBHC asserts:

The US-Mexico border region should be viewed as one epidemiological unit, despite the fact that it lies in two countries. The fourteen pairs of 'sister cities' that straddle the border reflect similar epidemiological issues whether the people live on the US-side or the Mexican side of the border...

A press release by the U.S. Consulate General in Ciudad Juarez announced that "HHS has recently invested \$5.5 million through the commission to improve laboratory capacity, surveillance, and training on the Mexican side of the border." The trend towards integration follows from economic ties. The USMBHC observes:

Mexico is the United States' second-largest trading partner...Exports to Mexico more than quadrupled between 1986 and 1994, going from U.S. \$12.3 billion to over U.S. \$50 billion and then doubled again by 2000 ...The United States-Mexico Border is recognized as one of the busiest in the world.

Not only do Mexican nationals work for less, but they are also major consumers of American goods on either side of the border. There appears to be at least some willingness to acknowledge the contribution made by Mexican workers. Jerry Seper from the Washington Times, in his article, *Mexico lobbies for alien amnesty; Uses coalition to seek benefits* observed that "Mr. Bush proposed a guest-worker program that could give legal status to millions of illegal aliens, mostly Mexican nationals, who hold jobs in the United States." The proposition was cited as the product of a "...growing political alliance" that "...also seeks expanded education and healthcare benefits." As economic ties continue to grow, it is reasonable to expect and hope for greater cooperation between the two countries. Despite the fact that the two countries are separate political entities, cooperation in regards to healthcare, including standards and information sharing, would be mutually beneficial. The department of Health and Human Services has invested millions through the USMBCH "to improve laboratory capacity, surveillance, and training on the Mexican side of the border." Other efforts include "support for 30 health centers in the border area" that provide "preventive and primary care to patients regardless of their ability to pay." In total:

The U.S. Department of Health and Human Services (HHS) through its Health Resources and Services Administration, spends more than 75 million each year to improve health care along the border. These resources provide residents with primary health care, maternal and child healthcare, HIV/AIDS care and support, and also underwrite programs to train and replace health professionals in the region.

Currently, the patient to physician ratio in El Paso is approximately 92 per 100,000 while the statewide average is 160 per 100,000. The expenses incurred by the state are substantial. However, as already stated they are insufficient:

...the State spends significantly less per-capita for Medicaid acute care services delivered on the Border than in other geographic regions of Texas...rates are based on historic utilization of healthcare services in a county. The Border has low utilization due primarily to the lack of health care providers and infrastructure.

The shortage of healthcare cannot be effectively addressed without also taking into consideration the need for physicians. The latter part of the statement which reads "...and also underwrite programs to train and replace health professionals in the region" seems particularly interesting since this is exactly what the proposed clinic would accomplish. Overall, setting up

clinic(s) affiliated with medical schools along the border seems not only to fit the current trends of integration but also the specific goals of government agencies presently addressing the issue. This strategy also avoids the political obstacles mentioned at the outset. A clinic set up in cooperation with Mexican medical schools would provide healthcare not only for Mexican nationals but also for U.S. residents and citizens who cannot afford healthcare. The educational benefits would also be twofold. Preventive care education for diseases prevalent along the border would benefit the public, while medical students, professors and medical professionals involved on both sides of the border would also benefit from the cultural exchange. Melissa T. Bell writes in her article, *Immigrants' Access to Quality Health Care*:

As the immigrant population grows and the country becomes more racially and ethnically diverse, health issues that are more prevalent among immigrants will likely gain more attention. For instance, there may be more demand for research funds devoted to diseases that affect the immigrant population disproportionately. Consequently, there may be a greater emphasis on prevention and treatment of these diseases, which is intertwined with the problems of cultural competency and health literacy as well as access to health insurance .

A physician's ability to effectively treat a patient is to some extent contingent on his/her ability to communicate with the patient. The same article states:

Health literacy is low among poorly educated people and non-English speakers. Immigrants' health depends on their ability to process medical information, so health care professionals will need to find ways to communicate more effectively with these groups. Inability to speak English well can serve as a barrier to health care access ... patients who do not speak English are less likely to see primary care physicians and use preventive care services and more likely to receive emergency room treatment ... patients with chronic illnesses, such as asthma, are less likely to go to follow-up appointments and follow their medication regimen if there are language barriers between them and their doctors.

This factor addresses the third prong required for NIW eligibility. The roundtable discussion organized by the Human Accountability Project, under the heading Principles of Biomedical Ethics, acknowledges that "The current trend ... is toward patient self-determination, with a partnership mode held as the ideal." Informed consent is defined as follows:

Informed consent is understood as a demanding requirement, involving good communication with the patient, and patient explanation of unfamiliar terms and procedures; and a choice (where appropriate) among effective options that permit patients to make medical decisions in accord with their personal goals and values.

Furthermore, such a program may also foster more effective means of information sharing, such as a universal patient history form that would facilitate or may minimize the need for translation. Fluency in both English and Spanish would be encouraged as well as standardization of medical services on both sides of the border. There's also the probability that such a program will facilitate legislation which could make it easier for Mexican doctors to practice in the U.S. Thus, the shortage of physicians may be reduced and cooperation as a whole would be encouraged. In regard to national security and long term benefits, the article *Texas Borderlands: Ground Zero of Health Issues* makes the following observations of diseases particular to the border region:

... these diseases are very costly for Borderland hospitals to treat, and if left unaddressed, they will continue to travel North and impact other parts of the state.

The costly treatment of these unique diseases coupled with high rates of infection pose a double threat to the Border Region...In addition, these areas often serve as a hub for frequent travel, increasing the likelihood of outbreaks in crowded living situations ... One person with untreated active TB will infect on average as many as 15 people per year ... Early detection is a key preventative measure in minimizing TB incidence rates in the state ... each case of TB costs \$13,000 to treat ... Economically speaking, the loss of productivity due to preventable disease incurs significant costs for the Region ... with health costs rising every year, individuals who may already deal with unemployment or low wages must face the added burden of paying, for medical treatment they cannot afford.

Clearly there is a pressing need to address healthcare on the borders. Failure to do so would not only worsen the situation in this region but would also eventually have a negative impact in other areas of the country. Thus, health, security and economic issues overlap. Not only are poor healthcare services linked to falling productivity, but cutbacks in existing healthcare programs inevitably lead to greater healthcare burdens for both the populace and government.

Conclusion

Education on health issues, patients' participation in preventive care, and greater cultural awareness on the part of physicians are key. From understanding, effective strategies and supporting legislation would result. Melissa B. Taylor asserts, "the healthcare system must adapt" as the nation becomes more diverse. Among the policy changes encouraged, she lists the following:

- * encouraging of mandating access to medical translation and interpretation services; and
- * promoting foreign language skills and cultural competency in college health care curricula and professional education programs

Also among the options listed is "creating incentives for employers to provide health insurance benefits." The first steps towards making health insurance available have already been taken . Included in this packet are also several articles and excerpts that may prove useful, including some contact information. As already stated, the border is unique in regard to healthcare needs. The overall trend is towards integration. This is the most realistic path. Not only do Mexican nationals receive healthcare in the U.S. but many native-born American citizens also seek more affordable healthcare in Mexico . It is only reasonable that better cooperation along the border, a realistic view of the issues, and mutual understanding should foster practical solutions .