

# **EXECUTIVE BRIEF**

## **U.S./MEXICO BORDER HEALTH AND HUMAN SERVICES POLICY ISSUES**



### **COMMUNITY HEALTH CENTER BORDER POLICY CONSORTIUM RECOMMENDATIONS**

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## **A. Introduction**

This Policy Brief is intended to further advance dialogue and approval of Border CHC policy issues and priorities agenda. It is intended to help organize the Border CHC Consortium and expand collaborative partnerships with stakeholders (institutional and grassroots) that will advocate their implementation.

## **B. Summary of Border Core Issues**

The first CHC Border Health Policy Forum generated an interdependent chain of priority issues. These issues are supported by documented public and private research, many of which are highlighted in the previously forwarded Profiles. The core issues from the Forum included:

**Issue 1: The population growth, demography, bilingual/bi-cultural, and bi-national economies, and intergenerational migration characteristics of the U.S.-Mexico Border uniquely challenge the capacity of Border CHCs to increase access to comprehensive primary health care.**

Since 1990, the border counties have experienced a growth rate of nearly 30%. High fertility, international migration, and intergenerational migration are the major reasons driving population growth, which is forecasted to continue. Twenty-two (22) percent of the population is foreign born compared to 11% nationally. The Border population is predominantly bilingual, bicultural Hispanic. Most are U.S. born Mexican American. Hispanics comprise 35.5% (23.6 million) and 52.1 % (3.6 million) of the Border States and Border counties respectively compared to the 14.7% of the total U.S. population. The Border includes seven (7) ports of entry and these crossings handle 90 percent of all southwest border trade and northbound commercial truck traffic.

**Issue 2 – Economic and Educational Insecurity: The CHCs have more rigorous service delivery and health improvement challenges because of the Border populations’ low education, economic and employment environment that negatively impact their *bienestar* (well-being) and health status.**

The **poverty rate** for children living along the Border is twice (37%) the national average (17%). About half-million children along the Border are poor and Hispanic (83%). Approximately 80% of Hispanic children who live on the Border come from working poor families. **Educationally**, in 2000, 73% of Border residents above the age of 25 had completed high school, compared with 80.4 % nationally, ranking Border counties 50<sup>th</sup>. Latino students are three times (15%) more likely to drop-out of high school compared to Non-Latinos (5%). The Border **unemployment rate** ranks 5<sup>th</sup> in the nation. Collectively, in 22 of the 24 Border Counties, the unemployment rate is double the national average (10% versus 5%), and their labor force participation rates are less than 58 percent compared to 65 percent nationwide.

**Issue 3 – Transnational Migration: The service capacities of Border CHCs are uniquely impacted because of the enormous daily bi-national border crossings (over 300 million annually) among U.S. citizens and documented/undocumented immigrant populations. They are at higher-risks that their service capacity and health improvement goals (individuals, family, and community) will be negatively affected by immigration policies that impede health care access.**

Border CHCs are the major first-line defensive against acute and costly illnesses, while also doubling as a critical public health provider in the early identification of infectious communicable diseases. While this role may impact non-border CHCs, it is intensified on the Border by constant crossings with greater impact on preventive and continuity of care issues (e.g., dual care from multiple providers, medications purchases/usage, chronic disease management, and reliability/validity of health information). Much of the current negative immigration debate and policies such as waiting periods for service eligibility and legal resident verification is negatively and disproportionately impacting Border CHCs. CHCs know from experience and research documentation that neither legal nor illegal immigrants are the major source of the health care problems in the U.S. or the Border.

The CHCs have a moral and legal responsibility as private non-profit organizations to provide primary health care to underserved populations. Their service strategies to address identified health problems in the communities are encased in this purpose. Immigration policies that directly or indirectly impede this purpose negatively effects prevention initiatives and reducing/controlling chronic disease, and multiply public health risks.

**Issue 4 – Uninsured Crisis: The appalling number of uninsured on the U.S. – Mexico Border and their devastating effect on Bienestar and health status are overwhelming CHC’s capacity to provide cost-effective preventive and chronic disease management health care.**

The U.S./Mexico Border States and Counties have the highest uninsured rates in the country (16%), averaging 20% among the Border States and 28% in their respective Border counties. The Latino population represents the largest percent, averaging 60% of all the uninsured. Among Latino subgroups Mexican American (35-40%) and document/undocumented Mexican immigrants (40-60%) are the most uninsured. While Border CHCs are committed and passionate regarding their role as safety-net providers, they cannot bear the full-burden for the uninsured. The CHCs and the many chronic disease patients they serve are, more than any, negatively impacted by the lack of access to secondary and tertiary specialty providers of care.

**Issue 5 – Health Care Inequalities: There are documented inequalities in the availability and distribution of basic public infrastructure, educational, economic development, and health care resources on the U.S./Mexico Border.**

There are well-documented inequalities in the availability and distribution of basic public infrastructure, educational, and economic development, and health care resources on the U.S./Mexico Border. Numerous studies demonstrate that ‘safety net’ resources in the U.S./Mexico Border State are much fewer compared to the national average. The weak infrastructure, combined with high number of uninsured, and low reimbursement rates to providers place major economic and service burdens upon health care providers, hospitals, trauma centers, and CHCs. Plus, fiscal pressures on Border taxpayers are greater, and the rapidly increasing numbers of uninsured further compete negatively with other community needs.

**Issue 6 – Severe Shortages of Health Care Professionals: Border CHCs have acute health care provider staffing needs, particularly for bilingual bicultural health professionals. Most of the U.S. – Mexico Border is plagued with a severe shortage of health professionals across primary care and specialist disciplines. The shortages include dentistry, pharmacists, nursing, and allied health professionals.**

About 1/3 of the border population lives in a Health Professional Shortage Area (HPSA), whereas in some Border regions, it is as high as 70%, -- e.g. the Texas Border. *The historic lack of health professional training institutions on or in the Border counties has contributed to the severe shortage of health professionals. However, regarding physicians, they are being undermined by the decreasing number of trained primary care providers, and the lower and inequitable provider reimbursement rates.* The severity is intensified by the lack of bilingual, bicultural Latino health professionals, particularly physicians, dentists, and pharmacists. To achieve parity with the Latino population today, the number of Latino health professional as physician would have to triple.

**Issue 7 – Border Health Improvement Zone: The multiplicity of health disparities and inequalities challenging Border CHCs service delivery exceeds their capacity. They encompass infectious diseases, chronic diseases, cancer, mental and oral health issues, substance abuse and negative socio-environmental problems (teen pregnancy, family violence, incarceration, etc.) on the Border.**

The recent CDC/National Center for Health Statistics ‘Health Disparities Report’ demonstrates that Hispanics health disparities and health status has worsened. Health researchers and demographers are projecting that the combination of Latino population growth, economic conditions, and health status will result in a disease pattern shift where they will increasingly represent the larger proportion of the prevalence of diseases and disorders over the next 10 to 20 years. This projected disease pattern already exists and is escalating on the U.S. – Mexico Border.

### **C. Priority Policy Issues - Recommendations**

1. The U.S. – Mexico Border must be designated as a “**Health Improvement Zone**” that recognizes the exacerbated disparities and inequalities in both health resources, and health problems and risks. The Health Improvement Zone designation must include specific public and private opportunities to address public health, health promotion and prevention, clinical preventive and chronic care management, health profession shortages, and health facility needs.
2. Federal and state government agencies and private sector institutions must recognize the positive social and economic benefits of the U.S. – Mexico Border counties in their respective States and the Nation. Policies must **stimulate and not create barriers to effective infrastructure growth and services**.
3. New public and private sector funding **partnership opportunities** must be developed that target expanding education, economic, public utilities, and the health services capacity of Border providers.
4. The Border CHCs must be **adequately funded** for their ‘front-line’ public health and primary health care services responsibilities on the U.S.-Mexico Border. They must also be provided the opportunity to access designated funding to implement service integration approaches that improve the primary health care infrastructure, and help leverage additional resources.
5. **New service approaches and funding strategies** must be **developed** that build on the experience and strengths of Border CHCs who have demonstrated innovated efforts in health promotion and prevention, clinical preventive and chronic care, integrated social, health and economic service models, health professions development and recruitment, and applied research.
6. **New funding** opportunities must provide support for innovative Border CHCs intended for demonstrations and/or base-funding increases targeting:
  - a. Culturally and linguistically responsive health promotion and prevention;
  - b. Chronic disease management services that utilize *promotoras* (lay health workers) as interdisciplinary team members;
  - c. Improve access and continuity to specialty care;
  - d. Health professions development models (medical, dental, and pharmacy residency and preceptorships, as well as nursing and allied health disciplines).
  - e. Increase capital funding opportunities to include grants, forgivable and low interest loans, and private sector economic development partnerships.
7. The Border CHCs must **strengthen their leadership and collaborations** to direct increased policy and advocacy attention to expand the Border’s public health and primary health care infrastructure, to increase health care access, and to help reduce the number of uninsured.
8. The Border CHCs must widen their collaborative partnerships using a **tiered approach to develop and prioritize strategic institutional, policy, and grassroots allies** (locally, statewide, and nationally).