FACTS Reports

Field Actions Science Reports

Special Issue 2 (2010)
Migration and Health

Jennifer Miller-Thayer

Health Migration: Crossing Borders for Affordable Health Care

Electronic reference
Jennifer Miller-Thayer, « Health Migration: Crossing Borders for Affordable Health Care », *Field Actions Science Reports* [Online], Special Issue 2 | 2010, Online since 01 October 2010, Connection on 25 October 2012. URL : http://factsreports.revues.org/503

Publisher: Institut Veolia Environnement
http://factsreports.revues.org
http://www.revues.org

Document available online on: http://factsreports.revues.org/503
This document is a facsimile of the print edition.

Field Actions Science Report
www.factsreports.org

FACTS Reports

Health Migration: Crossing Borders for Affordable Health Care

J. Miller-Thayer

Anthropology Department, University of California, Riverside

Abstract. Approximately 45.7 million people in the United States are uninsured and unknown numbers of this population are underinsured, severely limiting their access to medical care. To address this problem, people use innovative strategies to increase their access through cross-border care options. The U.S.-Mexico border provides unique challenges and opportunities for health care in this context. The lower cost of medical and dental procedures and medications in Mexico makes that country an attractive alternative for low-income populations in the United States. Thus segments of the U.S. population practice transnational medical consumerism in an attempt to optimize their health by using the resources available in both countries. This practice has economic benefits for the people who access health care at an affordable rate and for the medical markets of the country providing the care. Drawing on data collected in the field in 2002, 2004, and 2005, this paper presents some of the complexities and dynamics of medical pluralism occurring at the U.S.-Mexico border.

Keywords. Transnational medical consumerism, U.S.-Mexico border, health insurance, social networks.

1 Introduction

The recent U.S. debates on health care reform have highlighted the fact that, for large segments of the population, the medical system in the United States is absent or inadequate. These problems are not new, but they are being exacerbated by the current economic recession as more people are laid off, lose their medical coverage, and experience falling incomes due to "economic adjustments" enacted by employers. Though the people who are underserved by or excluded from the medical care structure may appear vulnerable because of their lack of access, the U.S. ideology of independence and their need for treatment motivates them to find innovative solutions to their pressing medical needs. This results in some people meeting their care needs by using another country's healthcare system (Darcé 2007, 2009; Bastida *et al*. 2008; Sweeny 2008; Llana 2007; Vitucci 2002; Berestein 2002; Landeck and Garza 2002; Corchado and Carbajal 2002; Associated Press 2001; Macias and Morales 2001; Fairbanks 1997; Garcia 1993; Belkin 1988).

In this context, the U.S.-Mexico border provides unique opportunities for health care. The lower cost of procedures and medications in Mexico makes it an attractive alternative for low-income populations in the United States. Thus portions of the U.S. population practice cross-border health care as transnational medical consumers. They attempt to optimize their health by making the best use of the resources available in both countries. Economically, this practice has benefits for the populations who access health resources at an affordable rate and for the medical markets of the countries providing the care, thereby providing incentives for the practice to continue as long as circumstances warrant.

Transnational medical consumers include seniors ("snowbirds"), year-round border residents, and day and weekend border crossers. A snowbird is someone 55 years or older, from the northern United States or Canada, who spends winter months in the warm U.S. South. Generally, snowbirds live in the Southwest for 5 to 6 months of the year, arriving in October or November and leaving in late March or early April. My research area of Southern California and Arizona

Figure 1. Transnational medical consumers waiting to cross back into the United States

Correspondence to: Jennifer Miller-Thayer
(Jennmiller21@aol.com)

is a popular destination for snowbirds, who come from Canada and a variety of U.S. states, including Kansas, Washington, Missouri, Nebraska, Idaho, Illinois, Michigan, Oregon, Montana, and Utah. Several have moved permanently to the Southwest and live there year round. While wintering in the U.S. South, many snowbirds stock up on medications, get glasses, and receive dental care in Mexico at rates that are lower than those in the United States.

Day and weekend crossers accessing medical care in Mexico tend to be members of at-risk populations, such as the poor, the uninsured, and the underinsured, who visit Mexico for a day or weekend to obtain care. Many, though not all, live in northern areas of the border states, though some hail from further north. Some day and weekend crossers take tour buses that originate in California or Arizona; others carpool with family members and/or friends from as far away as Minnesota, Oregon, and Washington. A few stay with family or friends for the weekend; others stay in hotels or RV parks. Individuals in this group are sometimes younger than the 55-year age marker that defines snowbirds.

Year-round border residents are an at-risk U.S. population because many border cities have high rates of poverty and, thus, higher rates of morbidity and mortality (Fairbanks 1997, 73-74). Nevertheless, border-area residents can benefit from their close proximity to Mexico and the less costly care options available there. They have the advantage of not having to travel far to access services in Mexico, and they can obtain care throughout the entire year. Additionally, there are border insurance policies available that cover the care border residents receive in Mexico. These provide incentives to access the less costly care across the border, which may result in a higher level of treatment than might be attained if these border residents were restricted to U.S. facilities only.

2 Research Design

This research was conducted on the Arizona and California portions of the U.S.-Mexico border and in Los Algodones, Mexico, in July-August 2002 and April 2004-May 2005. The data come from 33 semi-structured interviews and surveys taken from opportunity and snowball samples and participant observation with transnational medical consumers as they pursued health resources in Mexico. I have documented cross-border health care practices, contexts, strategies, and the perceptions of those accessing medical resources.

3 Research Findings

Table 1 shows the demographics of the people I interviewed. Interviewees were 65.8 years old on average. Sixty-four percent were female and 36% were male. Seventy percent were married, 15% were single, never married, and the remaining 15% were divorced or widowed. Their educational attainment consisted mainly of a high school diploma or some college but no degree. Most of the interviewees who stated their income fall below $65,000 annually, with the majority in the $15,000-$25,000 range.

Table 1. Interviewee Demographic Data

Characteristic	Count
Sex	
Female	21
Male	12
Age (in decades)	
Under 30	0
30s	2
40s	2
50s	4
60s	11
70s	10
80s	3
90s and older	1
Marital status	
Single, never married	5
Married	23
Divorced	3
Widowed	2
Education completed	
Less than high school	4
High school diploma	9
Some college, no degree	12
College graduate	5
Graduate school, no degree	1
Graduate school graduate	2
Annual income (U.S. dollars)	
Under $15,000	3
$15,000-25,000	6
$25,001-35,000	1
$35,001-45,000	3
$45,001-55,000	2
$55,001-65,000	3
$65,001-75,000	0
$75,001-85,000	1
$85,001-95,000	1
$95,001-105,000	2
Over $105,000	1
Declined to state	10
Insurance coverage	
Yes	31
No	2

4 Discussion

4.1 Why Cross the Border for Care?

One of the first questions people ask about transborder care at the U.S.-Mexico border is: "Why are people crossing into Mexico for health care?" The most common answer by far is, "It's cheaper there" (tables 2 and 3). One's ability to pay for health services and for insurance critically determines the type and amount of medical care one can acquire in the U.S.

system. Many people assume that those crossing the border for services have no insurance at all; however, most do have some coverage. Of those I interviewed, all but two have insurance (table 1). The majority have Medicare along with a supplemental insurance to cover some costs that Medicare does not. Some have coverage through employee retirement benefits, some are military veterans and receive insurance via a veteran plan, others have HMO or PPO plans such as Blue Cross and Aetna, and the Canadians have Canadian insurance plus a supplemental U.S. plan to cover them during their travels in the United States. The lowest income groups are eligible for Medicaid.

The problem with all of these plans is that the coverage is incomplete or the patient's share of cost is so high that people cannot afford the care and services available in the United States. For instance, prescriptions are so expensive in the United States that, without insurance or adequate coverage, many people cannot access this essential health resource. The few interviewees who had Medicaid had some prescription provisions during my research period; however, people would reach their maximum benefit within 6 to 9 months and then have to pay full price for their medications for the remainder of the year. Those with Medicare fared even worse since they had no prescription coverage. Phyllis explained: "Seniors have Medicare, but it doesn't cover medications, dental, or vision. The seniors come [to Mexico] for prescriptions. If you come at 10 a.m. at the gate, people older than us [their mid-60s] are there walking with canes, walkers, or in scooters, going for services."

Another way that Mexican health options have influenced the insurance market are the border health insurance policies offered to people working and residing in the border area (defined in miles from the border and specified differently by different insurance companies). Many employers along the border offer border policies to their employees. These policies, which cover care in Mexico with no or lower patient co-pays than a comparable U.S.-only plan, save money for both the worker and the employer. Employees must go to Mexico for eye glasses and dental and medical care. They can, however, receive emergency care in the United States. Co-pays are typically $4, and sometimes zero, in contrast to the average U.S. co-pay of $15.00 per visit. This alone can produce significant savings for the patient. Additionally, prescription costs are lower, since this co-pay is also nonexistent or lower than the comparable U.S. co-pay. The outlay for the employer is lower as well, which means that some employers

Table 2. Cost Comparison of Medications in the United States and Mexico

	Cost (U.S. dollars)	
Medication	**U.S.**	**Mexico**
Azucort triamcinolona cream	$6.50/tube	$2.50/tube
Cipro antibiotic (100 count)	$100.00+	$11.00
Advair inhaler	$200.00	$40.00
Ceftin (20 count)	N/A	$22.00
Sintrocid	$5.00/30 count (generic)	$17.25/100 count
Claritin D	$7.00/5 count	$11-12.00/20 count
Actonel (4 count)	$90.00	$53.00
Nexium (Prilosec), 40 mg (brand name)	$145.00/30 count	$32.00/100 count
Prilosec generic	$135.00/30 count	$14.00/100 count
Lipitor generic (100 count)	$186.00	$62.00
Allopurinol 300 mg.	$14.00/2-month supply (VA)	$5.00/2-month supply
Asthma inhaler (no brand)	$5.00/1 count	$5.00/3 count
Delanotin (700 count)	$700 (Rite Aid) / $380 (Walmart)	$42.00

Sources: Costs as reported by U.S. and Canadian consumers; RVnet.com

Table 3. Cost Comparison of Medications in the United States, Mexico, and Canada

	Cost (U.S. dollars)		
Medication	**U.S.**	**Mexico**	**Canada**
Vioxx, 25mg (100 count)	$357.00	$48.00	$149.00
Premarin, 625mg (100 count)	$32.00	$8.00	$19.00
Lopressor, 50mg (100 count)	$17.00	$8.00	$14.00
Salbutamol	N/A	$12.98/600 doses	$18.31/200 doses[a]
Flovent	N/A	$18.11/60 doses	$78.00/120 doses[a]
Prozac, 20 mg	N/A	$20.00/100 count	$98.00/80 count[a]
Penicillin, 500 mg (100 count)	N/A	$8.50	$50.00[a]
Servent (60 doses)	N/A	$24.99	$44.00[a]

Sources: Costs as reported by U.S. and Canadian consumers; RVnet.com. [a]includes $10.00 dispensing fee

who could not previously afford to provide health insurance to their workforce can now offer this plan to their employees (Darcé 2007; Berestein 2002; Mena 2002; Associated Press 2001). Thus the less expensive health care options available in Mexico provide a health care supplement to the more expensive (and, therefore, exclusive) U.S. health care system.

Clearly the savings on prescription drugs bought in Mexico can be considerable. Because many seniors live on limited and/or low incomes, have inadequate insurance coverage, and take more than one medication, they reap a particular benefit when filling their prescriptions in Mexico. Further, their lives are put at risk if they are unable to access these health-conferring resources; for example, many cut their pills in half or take their medications every other day in order to stretch their medication dollars. Others must choose between purchasing their medications or paying for food and rent. For the snowbirds and other transnational populations, the use of transborder health care allows them to solve their health care dilemmas by bypassing the lack of access in the United States and gaining access in the more affordable Mexican care system.

For example, Nancy, a retired nurse from Arizona, explains that she buys 12 of her 14 medications in Mexico, with her U.S. doctor's approval. Her thyroid medication costs $15 for one month of generic pills in the United States. In Mexico she gets 3 months of generic medication for $6, saving a total of $156 a year. She also buys Prednisone, Prozac, and Actonel for her osteoporosis there. Were she to buy Actonel in the United States, she would pay $810 a year (including her deductible); in Mexico she pays $636, for an annual savings of $174. Since she can purchase all of her medications in one or two trips to Mexico and carpools there with friends, purchasing her medications in Mexico is a very cost-effective option. Moreover, she reports that all the medications she purchases in Mexico are perfectly acceptable in quality.

Many snowbirds also receive dental care and purchase eye glasses in Mexico because those services are not covered by Medicare or carry high deductibles and co-pays under other types of insurance. Tony states, "[Care] is less expensive [in Mexico] most of the time." He explains that his wife's glasses cost one-fourth the U.S. price in Mexico, at $88.00, including the eye exam, versus $300 with insurance in the United States. Earl explains, "I have state insurance coverage for dental care, but the deductable is so high; that's why I come here [to Mexico]. I've been coming here for a month now for my dental work." He had a tooth pulled, a root canal, and got crowns and bridge work in Mexico for $800, care that he says would have cost $3,000 to $5,000 in the United States.

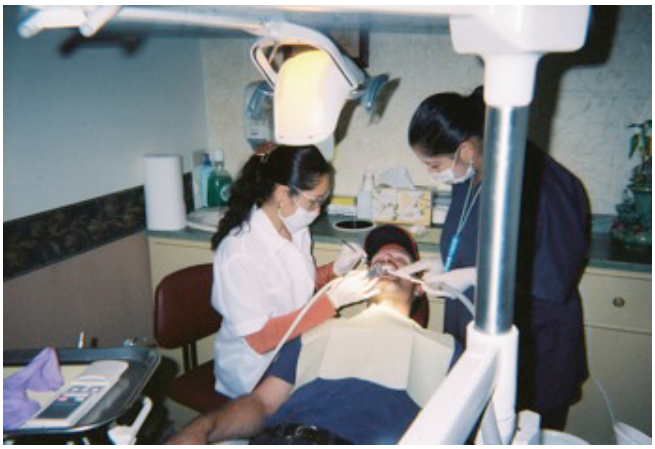

Figure 2. A transnational consumer getting dental work done in Mexico

Figure 3. A sign welcomes snowbirds to a business in Los Algodones, Mexico

This is an economic win-win situation for transnational medical consumers and medical providers in Mexico. Snowbirds access needed medical procedures and medications, and the medical industry in Mexico thrives. This cross-border medical access has brought tremendous growth in the health care sector in many Mexican border towns. For example, Los Algodones, a small border town that local U.S. newspapers have dubbed "the Mecca of medicine," had some 50 dentists' offices, 26 pharmacies, and 20 opticians' offices in a six-block radius from the border crossing in 2002 (Coates, Healy, and Morrison 2002). When I conducted my research there just a few years later, there were about 86 dentists' offices, 24 pharmacies, and 29 opticians' offices in the border zone, along with many physicians' offices, several barber/beauty shops, a health food store, restaurants, bars, souvenir shops and stalls, liquor stores, and a bakery. Furthermore, more offices were under construction.

4.2 Social Networks and Community

My findings show that social networks play an important role in shaping transnational health care practices and mitigating risks through the transferring of crucial information about which pharmacies, dentists, and opticians to visit, where to find the best prices on medications, and where and how to cross the border. In addition, many transnational medical consumers were introduced to cross-border health care by friends and/or family who already practiced this form of access. When asked how they started accessing services in Mexico, over 90% of the crossers I interviewed said they learned about them from friends, family members, neighbors, and other travelers who were already going to Mexico for such services. For example, Grace stated that her dentist "was recommended by someone who had been there. I didn't know her well [the recommender]. I see a lot of Americans there, I never see a Mexican there."

Further, 87% of those interviewed stated that they went to the same practitioners every time they went to Mexico for care, visiting the same eye clinicians and dentists but not

necessarily the same pharmacies, where medical consumers generally look for the lowest prices. Transnational medical consumers have built relationships of trust with their Mexican doctors, dentists, and eye care providers, and sometimes with pharmacists as well. I often witnessed patients catching up with the personal happenings in their providers' lives and vice versa, making plans to meet for lunch or dinner, or even to attend social functions together, such as a daughter's engagement party.

Although accessing health care transnationally is economically beneficial and possibly healthier for consumers and also beneficial for the health care markets of the countries providing the care, some interests, such as the American Medical Association and pharmaceutical companies, do not view this practice as either positive or healthy. Risk campaigns presented in the media stress the dangers associated with cross-border care. However, the social networks that exist among transnational consumers and providers mitigate many of the risks associated with buying medical supplies and services in a foreign country. These consumers are challenging the ethnocentric notion that health care in the United States is better than in other nations. Their empirical experiences debunk the myths of risk and danger that corporations, government, and the media perpetuate, a message these transnational medical consumers distrust because they view its sources as motivated by greed rather than concern for improving people's health. Their networking adds an element of safety; they can rely on the experiences of those who have gone before them and they can access the knowledge of those familiar with the new system to reduce their risk of harm.

5 Conclusion

It is easy to get caught up in the economics of this transnational strategy. As good consumers, we want to maximize our purchasing power, so we can easily see the rationale behind this behavior. However, these transnational medical consumers are not driven solely by a desire to save money, though this is certainly an important consideration. But it is essential to understand that their behavior is also tied to other health care aspects and contexts, such as insurance coverage and health perceptions, knowledge, needs, and practices. The market's pricing and lack of insurance coverage and availability have excluded them from medical resources in their home country. Medications and procedures that are not covered or not sufficiently covered result in a lack of access and lower quality of life and can even mean death. Therefore, the money-saving strategy of crossing the border is not only about comparison shopping and saving money to improve their economic status. It is about being able to afford access to these life-conferring assets to improve their quality, and in some cases their quantity, of life. It is precisely this point that makes transnational medical consumers so angry at the pharmaceutical companies and other medical providers. Their anger at the U.S. medical system stems from a feeling that it does not care about them as people, only as a source of profit—a stance they find incomprehensible when it is their lives that are at stake.

This research has practical implications for improving public health and insurance services for populations living in the border region through innovations in international cooperation projects on health, the facilitation of health care access for at-risk populations, and increased economic opportunities in health care on both sides of the border. The opportunity to help the people who are excluded from the U.S. medical system by accessing border resources is already evident in the practices of transnational medical consumers. While the issues surrounding this practice are complex and multifaceted, one option may be to expand border insurance policies to include non-border and temporary border residents in their covered populations. This would allow those seeking dental care, glasses, and medications in Mexico to more readily access these resources, and perhaps even increase the number of those able to benefit from this option. It is important to note that this solution is limited at best, given that it does not address issues of access within the United States. However, it may relieve the urgency for those now in need as they wait for a more comprehensive resolution to health care acquisition in their home country.

These findings underscore the disparities in insurance and health care access between population groups in the United States that drive the practice of transborder health care. At the heart of this practice are social networks of mobile populations connected through the Internet and shared locales during their winter migrations. At-risk populations, spurred by an ideology of independence and pressing health needs, have found their own way to overcome health care obstacles by crossing into Mexico and obtaining medications and services at an affordable cost. This transnational medical pluralism occurs where people's agency, needs, and willingness to traverse a national border combine with the economic incentives of Mexico to provide needed services to those populations. As long as the U.S. health care system neglects certain sectors of its population, this decades-long practice will continue.

Acknowledgements

The fieldwork was supported by grants from UCMEXUS, the Ernesto Galarza Applied Research Center (EGARC), and the University of California, Riverside Humanities Grant.

References:

Associated Press (2001), "Company Will Offer Trips to Buy Prescription Drugs in Mexico," December 19.

Bastida, Elena, H. Sheldon Brown, III, and Jose A Pagan (2008), "Persistent Disparities in the Use of Health Care along the US-Mexico Border: An Ecological Perspective," American Journal of Public Health, Vol. 98, pp. 1987-1995.

Belkin, Lisa (1988), "Health Care on the Border: Poor Go to Mexico," New York Times, October 12.

Berestein, Leslie (2002), "Health Insurance: Doctors without Borders," Time, October 14.

Coates, Ken S., Robert Healy, and William R. Morrison (2002), "Tracking the Snowbirds: Seasonal Migration from Canada to the U.S.A. and Mexico," American Review of Canadian Studies, Vol. 32, No. 3, pp. 433-452.

Corchado, Alfredo and Alfredo Carbajal (2002), "Mexicans Travel Back Home for Cheaper Health Care in Their Language," Dallas Morning News, May 7.

Darcé, Keith (2007), "Care in Two Countries; Mexican Workers Opt for Health Care Coverage That Allows Treatment on Both Sides of the Border," San Diego Union-Tribune, November 18.

——— (2009), "Mexican Health Care's U.S. Roster Up; Report: Recession Driving Uninsured Californians South," San Diego Union-Tribune, May 27.

Fairbanks, Jo (1997), "Health Care Access and Utilization on the U.S.-Mexico Border," in John G. Bruhn and Jeffrey E. Brandon (eds.), Border Health Challenges for the United States and Mexico, Garland, New York.

Garcia, James E. (1993), "Mexico Magnet for Prescription Drugs," Wisconsin State Journal, April 11.

Landeck, Michael and Cecilia Garza (2002), "Utilization of Physician Health Care Services in Mexico by U.S. Hispanic Border Residents," Health Marketing Quarterly, Vol. 20, pp. 3-16.

Llana, Sara Miller (2007), "Americans Now Flock to Mexico for Plastic Surgery," Christian Science Monitor, August 2.

Macias, E. P. and L. S. Morales (2001), "Crossing the Border for Health Care," Journal of Health Care for the Poor and Underserved, Vol. 12, pp. 77-87.

Mena, Jennifer (2002), "U.S. Insurers Tapping a Market for Cross-Border Health Coverage," Los Angeles Times, July 29.

RV.Net website (2004) Open Roads Forum – Snowbirds – Drugs in Mexico. Collected on March 5, 2004. Postings from Jan. 29, 2004 – Mar. 1, 2004. http://www.RV.NET

Sweeny, Camille (2008), "More Fun Than Root Canals? It's the Dental Vacation," New York Times, February 7.

Vitucci, Claire (2002), "RX for Rising Costs: New Option Lets Inland Union Members Buy Medications at Savings in Mexico," Press Enterprise, December 19.