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Medical Migration: Strategies for Affordable Care in an Unaffordable System

A Dissertation submitted in partial satisfaction
of the requirements for the degree of

Doctor of Philosophy

in

Anthropology

by

Jennifer Catherine Miller-Thayer

December 2010

Dissertation Committee:

Dr. Juliet McMullin, Co-Chairperson
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Dr. Thomas C. Patterson
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2010

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The text of this dissertation, in part or in full, is a reprint of the material as it appears in “Health Migration: Crossing Borders for Affordable Healthcare” in Field Action Science Reports (FACTS), October 2010; and “Politics, Economics and Health: Survival Strategies at the U.S.-Mexican Border” in the textbook Cultures of the United States, editions 1 and 2, published in 2006 and 2009 respectively.

DEDICATION

This dissertation is lovingly dedicated to my family members and mentors who offered support, friendship and endless encouragement before they passed: my father Joe Guresky, my grandmother Emma Oval, my Great Aunt Carrie Regnier and my mentors and friends Jim Bell, Michael Kearney and Ira Lipsky.

ABSTRACT OF THE DISSERTATION

Medical Migration: Strategies for Affordable Care in an Unaffordable System

by

Jennifer Catherine Miller-Thayer

Doctor of Philosophy, Graduate Program in Anthropology

University of California, Riverside, December 2010

Dr. Juliet McMullin, Co-Chairperson

Dr. Carlos Velez-Ibanez, Co-Chairperson

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 healthcare 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 healthcare 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 dissertation presents some of the complexities and dynamics of medical pluralism occurring at the U.S.-Mexico border.

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Chapter 1: Introduction

“Was it hard to get people to talk to you since they were illegal? How did you get them to trust you and talk to you?” It was a warm breezy summer day in central California and two of my good friends were getting married at a nearby vineyard. The questions came up while my husband and I waited with another couple for transportation that was to take us to the wedding. Though we didn’t know each other, we passed the time chatting amiably about how we knew the bride and groom. When I explained that I went to graduate school with both of them, they asked where I did my research. I responded that my dissertation research was on cross-border healthcare access at the U.S.-Mexican border. They were both very interested in my work since she was a U.S. medical technician and he was a dentist. Eventually, she asked the above questions. With both husbands looking on, I cocked my head to the side and gave her a quizzical look and responded, “Crossing the border for healthcare isn’t illegal. People do it all the time. They were very willing to talk to me about it.” With the images of the populations that I worked with at the border in mind, I was initially puzzled by her questions. Then I had the dawning realization that she had assumed that the people I worked with while conducting my research were illegal immigrants from Mexico who were crossing the border into the United States in order to access presumed “better” healthcare here. These same assumptions and ideas were expressed in another conversation with a man who “married into a Mexican family.” When he found out the topic of my research, he shared the story of his sister who died while attempting to cross the border back into the United States after arranging her mother’s funeral in Mexico, ending with the statement that

“crossing the border is very difficult.” His immediate representation of the border and the context of my research was that of Mexicans migrating into the United States under difficult and illegal conditions.

These questions and stories represent the essence of the issues that I was dealing with in my research. As Anglo citizens of the United States, they made several assumptions about my work that commonly shape how many people in the United States view immigration and healthcare at the U.S.-Mexican Border. They assumed that the people crossing the border for healthcare were only coming from Mexico into the United States; that they were crossing illegally and under difficult conditions; and that they believed that the U.S. medical system was better than their medical system was in Mexico (and thus worth the risk of crossing the border). This perception ignores the facts of the many Mexican people who cross the border into the United States legally every day, the many U.S. citizens who cross into Mexico every day and that the border is a gateway as well as a porous boundary between the two nations. These beliefs go hand-in-hand with the assumption that those who go to Mexico for care do so at great peril to themselves. But they also ignore the realities of cross-border healthcare in this region. In truth, most of the people that I worked with were U.S. citizens who were crossing the border into Mexico in order to access less expensive healthcare there, and those crossing from Mexico into the United States tended to be middle and upper income people seeking, and paying for, access to health technology. These perceptions are only half of the push and pull of discourses and imagery surrounding the border, including fear and risk, life and death, profit and loss, [modern and primitive], challenges and opportunities,

and value and cost-cutting that frame cross-border healthcare. The perceptions of those involved with and affected by healthcare access and provision surround the politics and economics of healthcare. Thus, the actual practices surrounding the strategy of cross-border healthcare are much more complex than the border myths, legends and stereotypes would indicate. This dissertation provides valuable qualitative documentation and understanding of the cross-border strategy and how this response to healthcare access disparities in the United States works to alleviate the health concerns for a variety of at-risk populations, such as the elderly, low income, and uninsured and underinsured people.

Background: The U.S.-Mexican Border and Health

The U.S.-Mexican Border area, defined by the 1983 La Paz agreement as 62 miles (100 km) on either side of the boundary line, provides a distinctive context for studying healthcare. This area can be conceived of as a 'third space' performing a multiplicity of tasks as it simultaneously encompasses structures, practices and beliefs from two different spaces, while filtering people, goods and ideas moving through the border, thus, creating a liminal region (Kearney 2004). It is also a microcosm of macro-level (nation-state) and micro-level (class) asymmetrical relationships between and within the United States and Mexico. Uneven access to care and health risks are visible on both sides of the border. Border populations in both nations share common characteristics of high rates of poverty and disease along with low rates of medical access (Fairbanks 1997). However, border areas are fluid and dynamic spaces providing unique opportunities for healthcare. As a result, innovative strategies of transnational healthcare emerge with people using services on both sides of the border wherever they are the most economical. Entities such

as insurance companies, pharmacies, clinics, and care providers operate differently at the border than they do in the interiors of their respective countries, due to the fluidity of the border. Furthermore, the connections between health, medicine and class structures at the border are reflective of the political economy of U.S. capitalism, the articulation of Mexico and the United States, and the class-based structures in both nations.

My research findings show that trans-border healthcare occurs at the intersection of multiple and integrated material and ideological levels. For example, there is the level of cultural definitions of health, disease and treatment; the level of economic markets for healthcare services and medications; the level of economically vulnerable populations such as the uninsured, elderly, and poor seeking medical care; and the level of institutions, manufacturers, researchers, and policy makers shaping healthcare delivery, procedures and costs. All of these levels are embedded within the ecology of the border area and are bound together by specific political economic relationships.

These patterns of care access reflect the economic aspects of each medical system. Many studies and newspaper reports suggest that medical politics and insurance coverage (or the lack thereof) and the cost of care strongly influence these healthcare practices (Darc 2009 and 2007; Bastida et al 2008; Sweeny 2008; Hawley 2007; Llana 2007; Corchado and Carbajal 2002; Landeck and Garza 2002; Macias and Morales 2001; Associated Press 2001; Arredondo-Vega 1998; Fairbanks 1997; Brandon et al 1997; Garcia 1993; Belkin 1988). The lower cost of healthcare procedures and medications in Mexico make it an attractive healthcare alternative for low-income and the un/underinsured populations in the United States. For example, prescriptions along with

certain types of care (i.e. vision and dental) cost significantly less in Mexico than the same care in the United States. Therefore, those with fewer resources for healthcare and who are able to access care in Mexico will do so to meet their medical needs more cost effectively. Conversely, access to technology is greater and often less expensive in the United States than in Mexico; thus, the easier access to technology makes certain healthcare procedures in the United States attractive alternatives for persons with middle and high incomes in Mexico (Arredondo-Vega 1998; Fairbanks 1997:77; Vargas 1978). Therefore, those with more economic resources will access medical care requiring technology in the United States in order to ensure the highest quality of care for their money. Thus, segments of both populations practice a transnational medical pluralism in their cross-border healthcare strategies (as will be discussed in chapter 2), as they attempt to optimize their health by making the best use of the healthcare resources available in both countries. Economically, this practice has benefits for the populations who access healthcare at an affordable rate, as well as, the healthcare markets of the countries providing the care. Some Mexican border towns build their local economy around providing services and merchandise for the U.S. citizens who come there for medical care and medications. The same is seen in the United States; for instance, a local border area hospital with a 'state of the art' birthing facility, located in California, offers patients from Mexico a discount if they pay for their birthing services ahead of time (most pay in cash) rather than being billed after the birth takes place. Additionally, some doctors, who are licensed to practice in both countries, will recommend that their patients (from both

the United States and Mexico) have their surgery in the United States and then recover in Mexico where costs of recovery are much cheaper.

While this practice is economically beneficial and possibly healthier for both populations, some interests, such as the Food and Drug Administration (FDA) and the pharmaceutical companies who sell medications in both countries, do not view this practice as positive or healthy. Stereotypes, misperceptions, and misinformation create further problems associated with this practice. Using a political economy of health approach from critical medical anthropology along with articulation theories provides tools for analyzing aspects of health risks and strategies in this region and how they are embedded in global contexts (chapter 2). For example, these frameworks help examine how the medical systems in both nations articulate to form one transnational configuration to circumvent the lack of access for U.S. transnational medical consumers (TMCs). My dissertation research, conducted between July-August 2002 and April 2004-May 2005, presents some of the complexities and dynamics of the cross-border healthcare occurring on both sides of the U.S.-Mexican border, as well as, how specific populations and institutions located in this dynamic area, meet healthcare needs within this particular political economic and transnational context.

Healthcare in Two Nations

The medical systems in Mexico and the United States are both biomedically based systems with various types of “alternative” therapies available as well. However, the ways that they are structured and accessed are different due to different conceptions regarding health, access to resources, politics and economics. This research documents

and analyzes the various conditions that shape the delivery and access of medical services in both countries for people living in the U.S.-Mexican Border region. The system in the United States is embedded in a capitalist political economic structure that bases access to healthcare resources on ability to pay and insurance coverage (which again can be linked to ability to pay, and/or employment). Medicare and Medicaid programs offer a public benefit for specific groups of people, such as the elderly over 65 years old and the poor. These programs do not cover all health needs, for example, Medicare does not cover dental care or eye glasses, and at the time of my research (2002, 2004-05), did not cover prescriptions either. This is problematic since seniors “consume almost 40 percent of all health care” (Arredondo-Vega 1998:168) and that will increase as the number of elderly rise with the baby boomer generation. Estimates suggest that by 2050 the number of seniors over 65 will rise to 68 million or 22 percent of the U.S. population (Ibid.). Most healthcare in the United States is “for profit” and there are few hospitals located in the border area. Considerable numbers of U.S. citizens lack access to healthcare due to the inability to pay, lack of health insurance, underinsurance, and/or living in rural areas with low provider access. The southern border area is one such area where medical service provision is low and poverty is high. This has influenced how healthcare is accessed and how employers and insurance companies deal with providing health insurance coverage, particularly with cross-border plans (discussed in chapters 2 and 5) (Darc 2007; Berestein 2002; Mena 2002; Fairbanks 1997).

In Mexico, health is a right guaranteed in the constitution and is mostly accessed through a more socialist mechanism; though private access based on ability to pay is also

present (Fairbanks 1997; Arredondo-Vega 1998:165-169). There are three options in Mexico: a public – based system for those who cannot access the social insurance services; the social services offered through *Instituto Mexicano del Seguro Social* (IMSS) (Mexican Social Security Institute) and the *Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado* (ISSSTE) (Institute for Social Security and Services for State Workers) as well as the services provided for the armed forces and petroleum and railroad workers; and the private sector where patients (often in conjunction with their family members) pay for services themselves (Arredondo-Vega 1998:165-166). While the best hospitals and physicians in the United States are in the fee-for-service sector of medical provision, in Mexico these are more often found in the social sector primarily due to the high cost of equipment that private doctors cannot afford as readily as a larger publically funded hospital can (Ibid.:166). In the late 1990s the IMSS offered to let family members of Mexican migrants living in the United States enroll if they pay a special fee. This provided them with full health coverage and low cost medications. Even with these options, there are high numbers of Mexican citizens who have no access to medical services due to where they live and the lack of access to providers and infrastructure. This is especially true of rural areas (Ibid: 165-167). Fifty – one percent of the population is covered by the social security forms of healthcare coverage, 2-3 percent pay for private services and the remaining 46-47 percent of the population receives health services from the state and is officially uninsured. In 2006 42.9 percent of those receiving care through the state were enrolled in a subsidized insurance plan called “*Seguro Popular*” and the government wants to have the rest of the uninsured

covered by this plan by 2010 (Taylor 2007). There is also a problem of accessing medical technology in Mexico due to the high cost of such equipment (Arredondo-Vega 1998). Therefore, both nations struggle with providing health services to all of their people. The border area provides them with a unique space to help alleviate some of these access problems.

During the 1990s there were many studies conducted on health at the U.S.-Mexican Border mostly due to an increase in Latino populations in the region and to NAFTA and its impact on the area (Arredondo-Vega 1998:169-170). Recently studies and newspaper accounts have been increasing again since the latest economic crisis in the United States has given rise to the belief that cross-border healthcare access in Mexico will climb as incomes plummet and health insurance coverage is lost due to job loss and/or loss of income (UCR SRC 2009; Darc 2009 and 2007; Bastida et al 2008; Sweeny 2008; Hawley 2007; Llana 2007).

Construction and Reconstruction of the Border since the 19th Century

My research area is situated in the California-Mexico portion of the border. As such, it is important to include the specific history of the development of the U.S.-Mexican border where it meets California along with the more general history of the border at large. This brief history¹ is vital to contextualizing cross-border healthcare where the state powers, individuals and social networks interact in the pursuit of controlling and accessing health resources. Heyman examines the political ecology of the border area as it reflects the two states' attempt to organize and control what happens

¹ This is just a brief overview of this history to provide a context for my research, for more detailed history on this area see Oscar Martinez, Carlos Velez-Ibanez, etc.

in their respective countries as well as at the nebulous boundaries (1994). He explains that part of this attempt at control is the creation of the ‘meaning’ and images of the border. As the state seeks to dominate the actions in this space, social networks and individuals circumvent this regulation through a variety of strategies; thus, there is flexibility at the border where rules may be more loosely followed and enforced than in the interior and where there is access to more than one set of rules (i.e. laws). This access to two sets of “rules” and the distance from the national center often results in opportunities for border economies and populations. Cross-border healthcare is such an opportunity that takes advantage of the two medical systems available at the juncture connecting Mexico to the United States. Disadvantaged populations in each country can find advantages in the nation next to them and thus, prosper in ways at the boundary that they could not in their respective interiors. Therefore, the history of how the border has been created, challenged, and recreated is essential to understanding the mechanisms surrounding this healthcare tactic.

The following history focuses on the political economic context of the border’s construction. While it does not specifically address the history of health at the border, it does provide the milieu in which cross-border healthcare developed as part of the interactions, connections, and survival strategies of border residents. Crossing the border to take advantage of the various opportunities provided on the other side and effectively using two systems to meet one’s needs is a norm in the border area that is taken-for-granted for border populations. As this brief historical overview suggests, the interconnections between the two nations indicates that the border is more of an

articulation point for two systems, rather than a barrier between two nations. Thus, it is not surprising that cross-border healthcare practices would emerge here.

The U.S.-Mexican Border currently stretches from Texas to California on the U.S. side and from Tamaulipas to Baja California Norte on the Mexican side. Its historically complex creation and maintenance is marked by both conflict and interdependence (Martinez 1996) as it performs the dual function of separating the two nations as well as inextricably binding them together. Along the approximately 1,550 miles of border are fourteen sister city pairs (one on the U.S. side and one on the adjoining Mexican side). Six pairs contain the largest populations: *Tijuana*-San Diego; *Mexicali*-Calexico; *Ciudad Juarez*-El Paso; *Nuevo Laredo*-Laredo; *Reynosa*-McAllen; and *Matamoros*-Brownsville (Arredondo-Vega 1998:164). These city pairs are tied together through trade, relatives, employment, tourism and as I documented healthcare access and provision. Though the common perception is that Mexican people cross illegally into the United States for healthcare, the documentation of border crossing refutes this. A study conducted in 1994 in *Tijuana* found that on average 300,000 people crossed the border there in a month for health services, 50,000 into San Diego and 250,000 into *Tijuana* (Arredondo-Vega 1998:164-65). My research finds the same pattern, more U.S. citizens were crossing into Mexico for healthcare than Mexican citizens were coming into the United States, and those who were coming from Mexico were paying for their services in cash.

According to Oscar Martinez (1983), the U.S. - Mexican Borderlands experienced "profound change" in the nineteenth century. In 1821, Mexico gained its independence from Spain, which took control of these lands away from the Spanish. In order to bring

more settlement to some of the lands in the northern area, Mexico invited/allowed U.S. citizens to move into the area now known as Texas. In 1826 the Texas Rebellion occurred starting off events that would lead to the Mexican-American War of 1846-1848. Prior to 1840 there were less than one hundred Anglo-Americans in Mexican California. This number increased to seven hundred by 1846 through wagon train arrivals (Meier 1983:50). Since Spanish-Mexican cattle ranchers occupied the "secularized mission lands, these newcomers began exploiting the agricultural potential of the region under the concerned eyes of Mexican officials" (Ibid.). This helped America gain California after the Mexican American War. As a result of that war, Mexico lost the towns north of the Rio Grande to the United States. The Treaty of Guadalupe gave the United States the present-day states of New Mexico, California, Nevada, parts of Arizona, Utah and portions of Texas. This land included millions of wild horses and cattle which came from the early Spanish settlers and which provided the impetus for the U.S. cattle industry (Gonzalez 2000:44). Additionally, the Gold Rush in California began about the time of the ratification of the Treaty of Guadalupe Hidalgo (Meier 1983:51; Gonzalez 2000:45-46). After this war, several new settlements formed in Texas from the old Spanish/Mexican ranchos and U.S. military forts formed during the war. Towns such as Nuevo Laredo and Guadalupe were established by Mexican 'refugees' from the United States on the south side of the Rio Grande in what was then, the new Mexican boundary line with the United States (Martinez 1983:53-54). Friction continued as "problems with slave hunters, smugglers, robbers, cattle thieves, and desperate characters of all shades who congregated in the borderlands further increased the tension between the two

countries" (Martinez 1996:xiv). American filibustering and Mexican "retaliatory raids" fed racial hatred. "By the late 1870s relations between the United States and Mexico had become strained almost to the breaking point as each country accused the other of failing to suppress border lawlessness" (Ibid.). There was a national depression in 1870 in the United States which "heralded the coming of a long period of economic, social, and political unrest that sharply modified the trend of California's history by the end of the century" (Meier 1983:51). The arrival of the railroads in the 1880s brought in an influx of settlers and "more civilized" influences which resulted in less "marauding and raiding" and ushered in three decades of "relative peace and order" at the border (Martinez 1996:xiv). Meier explained that development in California shifted to the South and that the arrival of the Santa Fe Railroad into Los Angeles "ended the Southern Pacific Railroad's transportation monopoly and helped lead to a rapid influx of settlers from the Midwest and East and an equally rapid decline of the southern *Californios*" (Meier 1983:51).

Agricultural changes in California from 1860-1890 resulted in "cow counties" in the south being transformed into family farms and towns. Pushed forward by the citrus industry, crops such as wheat, olives, sugar beets, cotton, grapes, avocados, and various fruits added to the "diversified agricultural boom" (Ibid.). Oil was discovered in Los Angeles, Fresno, Orange, Kern counties and elsewhere which led to an oil boom in the 1890s. "This economic transformation was fueled by a constant stream of immigration, which has been one of the enduring patterns in California history," beginning with those crossing the Bering Strait (Ibid.). Gold, railroads and land booms led to a population of

forty thousand in 1880 in San Diego (Martinez 1983:54). Due to the gold rush of the mid 1800s, immigrants from Mexico, Chile, Peru, Eastern U.S., France, England, Hawaii, Australia, and China came to California (Meier 1983:51). The native origins of immigrants changed over time to include people from Japan, the Philippines and India.

At the end of the 19th century, the border area experienced substantial growth. Cheap land and railroads created growth for West Texas, making El Paso an important center for transportation and trade in the 1880s. Cycles of boom and bust characterized this region from 1900 on, due to its interdependence on outside forces (Martinez 1983:54). Along the border in general at that time, American businesses began investing in various opportunities on the Mexican side of the border. For instance, "U.S. railroad companies, such as the Mexican Central Railroad, built important lines intended to link the mining and ranching areas of northern Mexico to processing centers and consumer markets in the United States" (Martinez 1996:xv). President Porfirio Diaz favored these enterprises after 1876 as he "believed that Mexico's modernization depended on the country's ability to attract capital from abroad" (Ibid.). He created the *Zona Libre* or Free Trade Zone within cities along the border. This type of trade existed among a few cities after 1858, but President Diaz extended this along the whole border in 1885, "pleasing *fronterizos* (borderlanders) who had lobbied for official recognition of their unique needs" (Ibid.:xvi). This opened Mexico to U.S. investment which reached \$2 billion by the time Diaz was expelled from office. U.S. investors controlled all of Mexico's oil, 76 percent of its corporations and 96 percent of its agriculture and by 1908 (3 years after the Free Trade Zone was eliminated) "the United States was consuming 80 percent of

Mexico's exports and supplying 66 percent of its imports" (Gonzalez 2000:52). Thus, the Free Trade Zone prompted considerable business activity as well as resentment from those in the Mexican interior, "where it was seen as both a detriment to the growth of native industries and an unwarranted special favor to one part of the nation" (Martinez 1996:xvi). The Zone was eliminated in 1905 by the Mexican government stating that it was no longer needed as the country's railroad system connected with most of the border area (Martinez 1996:xvi; Martinez 1983:54).

In 1910, the Mexican Revolution shattered the relative peace existing up to that time and began a "new era of instability, with Mexican bandits and revolutionaries raising havoc in the Texas and New Mexico borderlands" leading to many U.S. border residents to fear that Mexico would retake its lost lands from them (Martinez 1996:xiv; Martinez 1983:54). This tension decreased "as the violent phase of the revolution waned and as the United States turned its attention toward World War I" (Martinez 1996:xiv). During this period many Mexican workers were employed as low cost labor for the railroads, mines and cotton and fruit farms in the Western United States (Gonzalez 2000:77).

The cross-border trade which occurs in a large part through shopping across the border, helped to maintain the connections between the two countries despite the tensions between them. Tourism as an industry grew due to the increasing traffic to the border cities by those living in the interiors of each nation so that they could take advantage of the opportunities available on the other side of the border (Baerrensen 1983:122). For example, during the 1920s, thanks to Prohibition in the United States, many Americans

crossed the border for liquor and "other vices not readily available north of the boundary" (Martinez 1996:xvi). After WWI, California experienced a great economic boom which drew more than two million people as migrants to the state. Most went to the south to participate in the film industry and tourism. New crops such as cotton and lettuce changed earlier agricultural patterns. Industry bloomed in Los Angeles and San Francisco while the oil industry, shipping and construction also expanded (Meier 1983:51). This incredible development came to a halt with the Great Depression of 1929 which caused unemployment, poverty and slow growth (Meier 1983:52; Martinez 1996:xvi). "During the preceding two decades California had received thousands of workers from Mexico; now many Mexicans were repatriated while their places in migratory agriculture were taken by influx of economic refugees from Oklahoma and Arkansas" (Meier 1983:52). In the 1930s, it is estimated that 1 million Mexicans were expelled back to Mexico against their will (Gonzalez 2000:203).

"The greatest socioeconomic changes in the border lands have taken place since World War II, when the U.S. government began to invest enormous amounts of capital throughout the Southwest in military installations, defense-related industries, and infrastructure projects such as highways" (Martinez 1996:xvii). When capital is invested on one side, both sides benefit through the attraction of more people to take advantage of the tourism and shopping markets which make up a large portion of border trade.

"Traditional extractive and agricultural industries were pushed into the background and were replaced by manufacturing and high-tech industries that relied heavily on government spending. Trade and services became ever-growing sectors of the region's

economy" (Ibid.:xviii). These economic changes have resulted in high population growth in this region on both sides of the border as well as the evolution of the small struggling border towns into "modern, vibrant metropolises" (Ibid.). The pull of U.S. labor needs furthered the integration of the two nations at the border. WWII brought "unprecedented progress" to the border area through the expansion of agriculture, industry, trade, tourism and government spending. For example,

By 1950 about 800,000 people lived in the Mexican frontier, and by 1970 that figure had soared to 2.3 million, resulting in an annual growth rate of 5 percent during the 1960s (compared to the national rate of 3.2 percent). On the U.S. side, the population of the border counties increased from 1.5 million in 1950 to 2.6 million by 1970 (Martinez 1983:54).

The effects of growth and recovery caused by WWII were also seen in California. For example, airplane manufacturing and naval construction made California a leader in these areas. There were also increases in iron and steel manufacturing and oil production. The electronics and aerospace industries along with construction and automobile assembly also expanded during the post-war years. California's population grew to more than ten million by 1950, placing it second in the nation. The shifts in land ownership and agricultural production, along with other sociopolitical factors, resulted in mass peasant migrations to the cities in Mexico and eventually to the United States, where farm production increases during WWII created a high demand for inexpensive sources of labor. When other migratory populations from Asian and Europe were blocked during WWII, U.S. corporations persuaded the federal government to begin the Bracero Program in 1942 – 1964 to meet the needs of rising farm production (Menchaca 1995:90-91; Gonzalez 2000:103, 203; Martinez 1996:xvi). Agricultural production in California

expanded from \$626 million in 1939 to \$1,744 million in 1944, with the help of Mexican braceros (Meier 1983:52). Farming "remained the state's most important single industry, and California led the nation in producing wines, fruits, and vegetables and in their processing-bottling, canning, freezing, and drying. Twenty percent of the state's jobs [were] agriculture-related" as of 1963 (Ibid.). The Bracero Program allowed Mexican workers to be 'imported' for employment on U.S. farms for 6 month periods, with the option of renewing their contracts. The majority of these Mexican laborers were employed on large agribusiness farms rather than on smaller farms. This was pragmatically justified by the notion that the largest farms could produce more with more labor than the smaller farms could with more labor. Additionally, this was ideologically perceived as benefiting the country as a whole (Menchaca 1995:90-91). "Nationwide, throughout the duration of the Bracero Program, over five million contract laborers were imported..." (Ibid.:93). This had several benefits for both the U.S. and Mexico. For the U.S it : "1) lowered labor costs, which in turn increased the growers' profits, 2) enabled the United States to harvest massive quantities of crops, and 3) lowered the cost of food, thus benefiting consumers" (Ibid.:91). For Mexico, it reduced unemployment and stimulated local economies through remittances sent to families back home. Thus, the push factors of large scale unemployment in Mexico articulated well with the pull factors of the need for a large, low paid labor force in U.S. industrial agriculture. This political economic articulation between the U.S. and Mexico therefore, bolstered the U. S. dependency on this "cheap" source of labor, as well as, a dependency for the Mexican economy and communities on the remittances sent back to them. However, this program

was not beneficial for farm workers, domestic or 'imported,' for several reasons: 1) the larger available work force deterred strikes which stripped them of negotiating power and prevented them from organizing effective unions, and 2) their wages were kept low by the government working in accordance with recommendations from agribusiness associations (Ibid.).

Since the 1960s, "Mexico's frontier has experienced remarkably rapid growth, and attendant social problems have caught the attention of the public, policy makers, and academicians" (Martinez 1983:55). In the 1960s Mexico instituted the *Programa Nacional Fronterizo* (PRONAF) to improve the physical aspects of Mexican border cities so that they would be more attractive to foreign visitors. It also wanted to add products to these businesses so that Mexican citizens would not have to cross the border for their shopping (Martinez 1996:xvii). In 1965 the Mexican peso was substantially devaluated which further exposed the economic differences between the two countries (Baerrensen 1983:121). Additionally, the Border Industrialization Program (BIP) was instituted by Mexico in 1965 in response to the end of the Bracero Program which resulted in a large pool of unemployed labor. It consisted mostly of the *maquiladora* program, which allows foreign-owned assembly plants to be located in Mexico's border area. This has expanded beyond the border to include interior spaces in Mexico. (Martinez 1996:xvii; Martinez 1995:128; Baerrensen 1983:122). These *maquilas* were supposed to be "twin plants" with the Mexican plant assembling the product from parts imported from the twin plant located in the United States, then the completed product would be sent back to the United States and sold in its market. This was seen as a benefit to both countries as Mexican

people would not need to migrate outside of Mexico for work, and U.S. corporations could profit from the lower cost of labor in Mexico and the low tariffs associated with this program (Gonzalez 2000:234). Furthermore, the reason there is a plant on the U.S. side, instead of just one on the Mexican side, is that the rates of unemployment in border cities in the U.S. are some of the highest in the country. Additionally, many Mexican citizens have work permits allowing them to work in the United States and are usually paid the federal minimum wage, or less, and unionizing has been weak. This is seen as providing these cities with important sources of income that are not dependent on governmental policies and economic relationships between the two nations like "traditional principal income sources of international trade, retailing and tourism" (Baerrensen 1983:122). By the 1990s there were approximately two thousand assembly plants owned by American, Japanese and other foreign firms with more than five hundred thousand Mexican workers employed in them (Martinez 1996:xvii). Businesses with plants in Mexico included: General Motors, Ford, Chrysler, R.C.A., and Zenith. This investment was second only to oil and was followed by tourism (Ibid.:xvii).

One consequence of the *maquila* program was the tremendous population growth in the border region. "By 1990, 13.2 million people lived in the Mexican border states compared to 3.8 million four decades earlier; north of the boundary, the population of the U.S. Border States more than doubled, rising from 19.7 million to 51.9 million. Thus, the combined population of the greater borderlands totaled 65.1 million by 1990" (Martinez 1996: xviii). There was a combined total of 8.9 million living on both sides of the border in Mexican *municipios* and U.S. counties (Ibid.). Border twin cities such as

Calexico and *Mexicali* have experienced tremendous growth from 1950 to the present for a variety of reasons tied to climate, geography, labor costs and “global economic competition” (Martinez 1995:126-129). For instance, *Mexicali* grew from 64,658 in 1950 to 510,664 in 1980 and current estimates put the population at 1 million for 2002 (Ibid.). Additionally, Calexico grew from 6,433 in 1950 to 14,412 in 1980 and according to the 2000 U.S. Census it was 27,109 (Ibid. and U.S. Census 2000). As a result of all of this growth, various problems have also arisen. One of the most important is water, as 90 percent of the water used in California goes to agricultural requirements. Water and air pollution has damaged human health along with flora and fauna and "has generally deteriorated the quality of life in California" (Meier 1983:52).

This was the precursor to NAFTA and the beginning of U.S. owned *maquiladoras* on the Mexican side of the border. There are tax incentives included in this program since goods can be stored in warehouses at the border without paying U.S. duty taxes until the goods are brought into U.S. markets. The advantage of this is that many of the goods leave from these warehouses to non-U. S. markets in Canada, Europe or Asia and thus, bypass paying any duty in the United States. This allows Mexican goods to be exported through United States routes which are cheaper and less problematic than the Mexican sea routes. The tax breaks associated with this program increase the profit margins for participating U.S. companies, and have resulted in economic growth in this area. For example, according to the *Banco Nacional de Mexico*, in 1977 there were 404 assembly plants employing 69,000 people in the border area alone (Baerrensen 1983:122-

123), and by the time NAFTA was approved in 1993 there were 2,000 factories with 550,000 Mexican employees (Gonzalez 2000:234).

In 1994 NAFTA was passed in order to modify the earlier *maquila* program. This agreement produced a new “common market” between Mexico, Canada and the United States with the goal of removing all tariffs between them by 2010 (Gonzalez 2000:242). NAFTA and its associated organizations such as the Commission of Environmental Cooperation (CEC), the Border Environmental Cooperation Commission (BECC) and the North American Development Bank (NADBANK) were supposed to help alleviate several of the health and environmental problems at the U.S.-Mexican border due to the tremendous growth of the *maquila* industry in Mexico. Significant numbers of new jobs were supposed to be created in the United States and Mexico which would help stem the immigration from Mexico into the United States since the economic push of poverty would be alleviated. However, the promises made by NAFTA have not come to pass (Ibid: 242-244; Public Citizen 1996a:3-5). The *maquilas* did not end up providing relief for the unemployment problems seen in Mexico, since they employed young women rather than men because they were seen as easier to control (Gonzalez 2000:234-235). Undocumented immigrants and employee displacement are also related to NAFTA (Gonzalez 2000:242-3; Hackenberg and Alvarez 2001:100; Barnes et, al. 1997:131-135). Additionally, it has affected the ecology and development of the border negatively. The problems linked with this development include unmonitored dumping of human waste (sewage), industrial wastes, over taxing the resources, lack of housing and infrastructure for the population growth spurred on by the growth of the *maquila* industry and

increasing air and water pollution (Public Citizen 1996a:3-5; Gonzalez 2000:244).

NAFTA was supposed to stop the over-development occurring at the border and open up the interior of Mexico for further development. This was going to shift the burden of population growth and destructive environmental practices from being concentrated at the border and basically spread these risks out among the larger spaces of the interior (Public Citizen 1996a:5). However, due to the lack of infrastructure, border economic incentives (such as special tax rates and easier transportation across the border) this has not happened. In fact, *maquiladoras* are growing at a faster rate than before NAFTA and now include other foreign investors from Japan, Korea and India as they can use Mexico as a 'back door' to importing more than their quota of goods by bringing them in to the United States through Mexico as Mexican products (part of the manufacturing or assembly occurs in Mexico and then it is deemed a Mexican product) (Public Citizen 1996a:7). Furthermore, the economic stability that NAFTA was supposed to provide to Mexico did not materialize.

NAFTA came out the convergence of several asymmetries in the political economic relationship between the United States and Mexico, including issues of foreign loans and debt that reflects the articulation of dependency between these two nations, particularly in the 1990s when U.S. holders of Mexican loan notes demanded payment and Mexico was unable pay. U.S. President Clinton arranged a loan for Mexico to cover the debts. However, this loan came with conditions, including that the "...process of privatization and structural adjustment that began in the late 1980s [was] to continue and that the political system [was] to be opened" (Acosta-Belen and Santiago 1998:39). This

led to destabilizing political economic conditions, such as the depreciation of the peso that lowered purchasing power and raised the cost of imports eventually including basic consumer goods. There had been 2 peso devaluations in the 1980s and in December 1994 the peso was further devalued by another 50 percent (Gonzalez 2000:235). “By midyear 1995, the Mexican peso had plummeted 50 percent against the dollar, a million Mexicans had lost their jobs, and interest rates had skyrocketed to the point that Mexican consumers were paying as much as 100 percent interest for credit card loans” (Ibid.:243). This spawned an increase of Mexican immigration to the United States due to economic necessity (Ibid.: 242-243; Acosta-Belen and Santiago 1998:39). In fact, according to Acosta-Belen and Santiago, "the increase in U.S. (im)migration from Latin America and the Caribbean during the 1980s is clearly linked to the declining standards of living in these countries..." (1998:39-40; see also Gonzalez 2000). Though the *maquila* program continued to grow, with the number of workers in the *maquila* almost doubling by 1998 to almost 1 million, the Mexican workers are still suffering from high rates of poverty. “In 1997, the purchasing power of their wages was still one-third below 1993 levels. The depression that followed devaluation threw 1.8 million people out of work and bankrupted a third of all businesses. Today [2000], nearly half of Mexico’s 92 million people live on less than \$5 a day and 65 percent of the labor force is unemployed or underemployed” (Gonzalez 2000:244). The trade surplus of \$1.7 billion that the United States had with Mexico in 1993 became a \$14.7 billion trade deficit by 1998 (Ibid). The perpetuation of these conditions will result in the continuation of high rates of migration from Mexico to the United States (Ibid.:96-97). The history of the border indicates how

closely tied these two are politically and economically. Their articulation is particularly evident in the border space linking them together. This sets the stage for contemporary cross-border healthcare challenges and opportunities.

Trade at the U.S.-Mexican Border also includes health services. This is one area where Mexico gains jobs and profit and U.S. citizens gain a less costly product that can increase their quality of life; thus, both nations can benefit from this exchange (except for those who lose profit to the Mexican economy for health services). Arredondo-Vega (1998) examines this type of trade after NAFTA has been in effect for several years. He suggests that the two main components to this practice of cross-border healthcare access are the high cost of care in the United States and the difference in how medications are controlled in the two countries (162). One benefit of NAFTA for health services is that the tariffs on medical equipment imported into Mexico were removed which would help make this necessary health item more readily available there than it was before. However, even with this provision the cost of such items when new is still often prohibitive and problematic for Mexican healthcare providers; thus, many buy used or refurbished equipment (Ibid: 166). Private practice in Mexico is seen as very lucrative and beginning in the 1990s many investors began developing and improving healthcare centers in the border region to meet the demand by U.S. citizens for their services. This resulted in an increase of medical services of good quality to draw those populations into Mexico and the strengthening of these border towns' economies based on healthcare provision. This can also raise the health of the Mexican populations living in and around

these towns since medical access would be more readily available in these areas (Ibid.:166-67).

The push and pull of U.S. consumers of healthcare into Mexico is located at the nexus of several factors. The high cost of healthcare, the difficulty of accessing health insurance, the lack of items covered by Medicaid and Medicare in the United States coupled with the lower cost of services and medications in Mexico, the presence and availability of skilled doctors, dentists and nurses, the different distribution of pharmaceuticals, shorter, or no, waiting periods to see a provider, good quality treatment and services, and the relative ease of crossing the border for U.S. citizens combine to create the perfect conditions for the strategy of cross-border healthcare into Mexico for U.S. populations. At the same time, greater access to medical technology and hospitals in the United States draws higher income Mexican populations into the United States for healthcare (Arredondo-Vega 1998:171; Fairbanks 1997). Therefore, these border spaces provide unique opportunities for individuals and communities to address disparities in healthcare access present in both nations through a strategy of bi-national care access readily available at the border.

Methodology

For my dissertation I collected data that helped me identify three issues: 1) the connection between social networks and transnational healthcare processes; 2) the reasons why people participate in cross-border healthcare; and 3) the global political and economic factors shaping cross-border care processes. Toward this objective, I

conducted 13 months of ethnographic fieldwork consisting of participant observation² and qualitative, semi-structured interviews and surveys taken from opportunity and snowball samples in Calexico, California, Yuma, Arizona and *Los Algodones* and *Mexicali*, Mexico in 2002, 2004 and 2005. These are key locations for this type of research because they experience high rates of cross-border healthcare and share common characteristics with other border cities (Vitucci 2002; Medd 2002; Fairbanks 1997). All interviews were conducted with persons over the age of 18 in English or Spanish, whichever language was preferred by the interviewee. Most interviews were conducted face to face; however, a few were conducted on the telephone for the convenience of the interviewee. All appropriate IRB guidelines were followed throughout the gathering, analyzing and presentation of the data.

In order to understand why people participate in cross-border healthcare I examined healthcare access and decision making regarding healthcare for transnational medical consumers (TMCs) and healthcare providers. TMCs include snowbirds (elderly migrating population from the northern United States and Canada), day and weekend crossers and year-round border residents. Interview data includes the types of healthcare available and accessed in this area, treatment options prescribed and obtained, payment methods, insurance coverage issues, barriers to care and the role of cross-border strategies. I visited the doctors, eye care, dental offices and pharmacies with TMCs, observing the interactions between the patients and providers, the choices presented and

² Participant observation is an anthropological method that entails participating in and observing the day to day events of individuals while living in the communities under investigation in order to add empirical data to survey and interview data for a fuller view of the issues being researched. It is the primary method for ethnographic research.

made and the factors involved in the decision making process. Additionally, I observed the outcome of these processes on the health of the individuals by viewing them in their daily lives as a participant-observer living in their community. I worked closely with key informants who gave me permission to interview them and to attend their healthcare appointments and visits with them. Descriptive field notes were taken to record my observations (Bernard 1994). I recorded the health contexts, strategies, practices and perceptions of those accessing and providing medical resources.

Interview participants were selected through snowball sampling techniques using several different start points, or “seed” individuals in each population to provide a more balanced sample (Ibid.). While the external validity is low with this type of survey sample, when combined with ethnographic data this type of sampling is frequently “highly credible” (Ibid.:94). My preliminary research during the summer 2002 focused on making initial contacts and building networks within the border communities and medical service personnel in *Los Algodones*, and *Mexicali*, Mexico, Calexico, California and Yuma, Arizona. These provided the start points or “seeds” for my samples. My beginning seed contacts included family members related to me through my brother-in-law who lived in Calexico, California and *Mexicali*, Mexico, community contacts that I made during my preliminary fieldwork in 2002 and a Yuma snowbird. Initially, I began with snowball samples since the social connections and introductions from seed individuals would help to ensure higher rates of participation; however, as I became part of the TMC network, I no longer relied solely on introductions to access participants. I was able to engage participants in *Los Algodones* randomly as they waited for services, to

cross back into the United States, or rested in one of the plazas during their visit. Even so, introductions and my own social connections continued to play an important role in my access. Thirty-three semi-structured interviews with TMCs are analyzed in chapter 3 to understand how people began using cross-border healthcare alternatives, how and what information is shared on trans-border care, how this is reflected in actual practice, and community creation for TMCs.

In addition to the TMCs I also interviewed various medical professionals, such as doctors, nurses, and staff, along with Border health researchers from both nations. For example, I was able to interview, and gain contacts, from three professors at *La Universidad Autónoma de Baja California* (UABC). They provided me with information on Mexico's healthcare system as well as introduced me to medical personnel who became seed individuals for a snowball sample of healthcare providers in *Mexicali*, Mexico. This resulted in nine interviews including both private and IMSS level providers. Additionally, I conducted interviews with ten healthcare providers, including dental, eye care, pharmaceutical and hearing aid professionals, in *Los Algodones*, Mexico. I also began my own participation in obtaining services in *Los Algodones* and introduced people from my own social network into cross-border practices there which provided a high level of participation access in this process. To explore how insurance providers operated in this border context, I interviewed two employer insurance personnel, one from the farm industry and one from the Calexico City Hall, that offer border insurance plans that provide services in Mexico for their employees at a cheaper rate than comparative U.S. only plans.

Organization of the Dissertation

The next chapter, chapter 2, lays the theoretical foundation of analysis for the strategy of cross-border healthcare, placing it in the political economic context of access to, and control of, resources. Articulation theory illuminates how the United States and Mexico articulate at the Border region to form a space that allows border populations to use resources from both nations to meet their unmet health needs. Globalization and transnationalism frameworks provide tools for the exploration of how communities and networks transcend national boundaries. These transnational populations include healthcare providers and TMCs as well. Social networks play a crucial role in introducing new TMCs to cross-border health strategies including reducing possible risks associated with access in a new system. Political economy of health and critical medical anthropology approaches examines how structural barriers impede healthcare access as well as the role of individual agency in circumventing them. These various theoretical approaches combine to provide a more complete view of how health as a resource is valued, controlled and accessed on both a macro and micro level.

The third chapter examines the practice and beliefs associated with cross-border healthcare through the experiences and perceptions of the transnational medical consumers (TMCs) who obtain medical and dental services in Mexico where it is more affordable for them. This chapter provides demographic information on the TMCs along with documenting their use of social networks to provide valuable information on transnational healthcare. How they began accessing care in Mexico, why they access care there, and their perceptions of the U.S. and Mexican medical systems is presented.

Insurance coverage, medication costs, and patient/doctor relationships in relationship to the TMCs care access are also examined. Additionally, the economics of Mexican border towns providing care to U.S. residents is analyzed in relationship to their participation in this care strategy.

Chapter four provides three case studies exploring how cross-border healthcare operates for TMCs as they access various care options such as dental care, hearing aids and prescription purchases. Following my participation and observation of access in Mexico, I am able to obtain hearing aids for myself through this cross-border strategy. Additionally, I become the center of a social network that provides the opportunity for my friends and family to also become TMCs. Their trust in my knowledge about providers, services and medications encourage them to explore transnational care as a way to meet their care needs. Furthermore, these case studies illustrate the relationships between the Mexican practitioners and U.S. patients as well as within the TMC community.

The fifth chapter examines how the construction and perception of risk operates in the border region and with cross-border healthcare practices. The perception of the border as a dangerous space due to its fluidity and marginality plays into these portraits of risky medicine. Warnings on the risks of the Mexican medical system are produced by the FDA and disseminated through various media outlets to the TMCs and the general public. These are designed to protect the consumers, however, the experiences and observations of the TMCs contradict the issues raised in the warning information making them distrust the institutions presenting them. How the TMCs use social networks and

shared information to reduce their risk is also examined. In addition, the presence of these risks in all medical systems is discussed using examples from the United States system.

The final chapter offers conclusions and possible avenues of further research and action in healthcare access to help people effectively meet their health needs. Future research into the strategy of cross-border healthcare includes examining the effects of the recent legislative changes made in the United States and how that is affecting medical choices and decisions for TMCs. A comparison between the Canadian-U.S. Border and the U.S.-Mexican Border for transnational consumer practices is also suggested. The way that states in the United States are attempting to change the access patterns for their residents is explored in relation to the pharmaceutical companies' reaction to their efforts. Additionally, a comparison between the healthcare costs and outcomes in the United States and other nations is presented with the goal of exploring options for changing and improving the U.S. system.

Conclusion

Transnational healthcare processes shape, and are shaped by, local and global political economic structures of both nations as well as the U.S.-Mexican border itself where populations from both countries use bi-national strategies to make up for the deficits in healthcare available in their respective states. The implications of this practice for medical markets, patient health, insurance coverage, and border town economies are enormous. The empirical data provided by my investigation enhances our understanding not only of asymmetries in healthcare, but also how individuals and social networks use

their agency to find creative solutions to problems using the flexibility and opportunities provided in the ambiguous spaces created at the margins of social order.

Chapter 2: Articulation, Globalization and Critical Medical Anthropology

Introduction

The U.S.-Mexican Border is often perceived as a rigid boundary simultaneously binding and separating the two countries, a line to be crossed in order to enter into a different world. It is a barrier thought to keep people (and things) both in and out. It is often seen as a dangerous, marginal space where one nation's control and hegemony can be challenged, and/or bypassed by another's; where institutional control can be subverted by individual desire, need and/or action. Previous studies have examined health for populations inside the United States as a single nation phenomenon within the context of acculturation, socioeconomic status (SES) and public health interventions (Davidhizar and Bechtel 1999; DHHS 1998; Scribner 1996). Thus public health approaches act on the underlying assumption that once Mexicans migrate to the United States they do not maintain an interactive relationship with Mexico. This implies that their health service utilization patterns are restricted to the U.S. side of the border. Additionally, U.S. nationals are assumed to restrict their service utilization to their country of origin. Thus, the individual risk factors used to assess health in relation to SES or healthcare access only measure these factors from the U.S. side of the border missing the connections (political, economic, social and medical) to Mexico. This is not sufficient for explaining health and health-related contexts for the heterogeneous populations living in Mexico and the United States. Border populations, as part of that dynamic third space, are transnational populations which are not confined to either the United States or Mexico, but rather are able to move across the geopolitical boundary between them to access

resources and services in both nations, to meet their needs more economically, effectively, and efficiently. Border studies on health (Martinez, K. 2003 and 2001; CSA 1990; Vargas 1978; Bruhn 1997 and Fairbanks 1997) along with my research (2002, 2004-05) show that a high rate of cross-border healthcare utilization is occurring at the U.S. – Mexican border. In response to the uneven access to care and health risks visible on both sides of the border, innovative strategies of transnational healthcare emerge with people using services on both sides of the border wherever they are the most economical. As a result of the fluidity in this area, entities such as insurance companies, pharmacies, clinics, and care providers operate differently at the border than they do in the interiors of their respective countries. My research findings show that trans-border healthcare occurs at the intersection of multiple and integrated material and ideological levels. For example, there is the level of cultural definitions of health, disease and treatment; the level of economic markets for healthcare services and medications; the level of economically vulnerable populations such as the uninsured, underinsured, elderly, and poor seeking medical care; the level of ideologies of individual responsibility and autonomy; and the level of institutions, manufacturers, researchers, and policy makers shaping healthcare delivery, procedures and costs. All of these levels are embedded within the context of the border area and are bound together by specific political economic relationships. Therefore, my dissertation research combines the knowledge, theories and analytical models of globalization, transnationalism, border studies, and critical medical anthropology into a comprehensive macro- and micro-level understanding of cross-border healthcare.

The connections between health, medicine and class structures at the border are reflective of the political economy of U.S. capitalism, the articulation of Mexico and the United States, and the class-based structures in both nations. Articulation theory and globalization studies illuminate the interconnected relationships between the United States and Mexico expressed at the border and their articulation with national and bi-national border health contexts (Kearney 1995, 1996, 2004; Wolf 1997, 2001; Gunder Frank 1966, 1996; Gray 1986; Velazquez Flores 1996). Additionally, health can be viewed within the context of these theories as a potential cost and benefit to be shifted between the United States and Mexico (Kearney 1995, 1996, 2004). I will analyze these connections along with the economic and political forces structuring the practice of trans-border healthcare, the medical systems in the United States and Mexico, and medicine for profit using the theoretical models of political economy of health. Several critical medical anthropologists use the political economy of health approach to interrogate the ethics of medical systems, both local and global, in relationship to political and economic structures that produce poverty and inequality, including unequal access to health sustaining resources, which often results in substandard health for many people (see Baer, Singer, Sussser, and Farmer). This leads many scholars to argue that health conferring resources (such as nutritious food, clean water, safe housing, medical technologies and economic security) should be available equally to everyone. This is in direct challenge to those who support selling medicine and health as a commodity in a market system for profit. These two opposing ethical standpoints clarify the present tensions surrounding healthcare in the United States, and the world, today. They are also pertinent to the

cross-border healthcare practices occurring at the U.S. – Mexican Border, as different medical groups with different stakes and access to power and authority in the medical industry push and pull consumers (a.k.a. patients) from one country to the next in pursuit of quality and affordable healthcare. Paul Farmer explains, “in the United States, investor-owned health plans have rapidly transformed the way we confront illness...the primary feature of this transformation has been the consolidation of a major industry with the same goal as other industries: to turn a profit” (2003:163). With profit being the main goal of medicine, specific ethical questions arise about whether or not good health is a right or should only belong to those who can afford it. This includes questioning how “good health” is defined, by who and for what reasons. Issues of access and quality, along with supply and demand, become the central focus of medicine rather than healing people. Those with limited resources, the poor, elderly and children, face severe consequences in this type of medical system; therefore, “what’s at stake, for many of the poor, is physical survival” (Ibid.145).

Global Frameworks: Political Economy, Dependency, Articulation

Several theories contribute to the understanding of the constantly changing dynamics of the U.S.-Mexican Border region. These include political economy, world systems, dependency, and articulation theories as they relate to theories of globalization and transnationalism. Marx's conceptions of 'modes of production' and 'commodity fetishism' provide a basic foundation for these theories (Kearney 1996:82). Marx explains that, "a definite form of production thus determines the forms of consumption, distribution, exchange, and also the mutual relations between these various elements"

(Elster 1998 [1986]:9). They, therefore, are the base from which technology, social structures and ideology of the society are produced and reproduced. This concept attempts to reveal "...the political-economic relationships that underlie, orient, and constrain interaction" (Wolf 1997 [1982]:76). Furthermore, it elucidates the "...strategic relationships involved in the deployment of social labor by organized human pluralities" (Ibid.76). Marx recognized political economic interdependencies and interconnectedness of modes of production as a global phenomenon (Ibid.228). Thus, colonial and neo-colonial relationships between the 'core' and 'peripheries' involving the production of surplus, extraction of raw materials and organization and procurement of labor can be effectively examined through the concept of 'modes of production.' This also includes the production and consumption of health and healthcare. In the United States, we tend to not 'prevent' disease, rather we 'treat' it. It is the individual's responsibility for their health and access to health resources, not the society's. This extends to the argument over whether the United States should move to a "single payer" system of healthcare or maintain the capitalist "for profit" medical model. This is connected to ideologies of which model will promote "growth" and "innovation" in treatments and overall health of the population (it is important to note that most of the people arguing these points are people who have the ability to access healthcare under the current system so they are afraid of what change will bring to their access patterns, which links to their security in the current system as well [PBS Frontline 2003, Sapolsky 2005]).

Commodity fetishism, the second foundational conception, is an important feature of capitalist production according to Marx. It is generated through the disjuncture

between the laborer and the product of his labor within capitalism. Private land ownership and industrialization creates a system of oppression for the laborer as the need to work for his own subsistence is substituted with his work for a commodity. Labor becomes objectified resulting in "...objectification as *loss of the object and bondage to it*; appropriation as *estrangement, as alienation*" (Elster 1998 [1986]:37, italics in original). Thus, the worker becomes isolated from his labor production and as a result loses control and power over it and his livelihood. These production practices also lead to differentiation of wealth and class struggle. Marx explained that "in exchange value, the social connection between persons is transformed into a social relation between things; personal capacity into objective wealth" (Ibid.49). Commodity fetishism in capitalist modes of production creates the commodification of labor as peasants are pushed from their land and lose control over their production and consumption patterns and are thus, transformed into dependent wage earners. This creates specific uneven relationships within, as well as between, nations. The loss of control over labor and survival along with uneven access to resources is mirrored in differential health and healthcare access, and the strategies individuals use to compensate for this unevenness. This is intimately tied with the costs of health production and access along with access to insurance as health saving resource that many used to access through their employment (this has been declining since healthcare costs have risen in recent years). Insurance coverage or the lack thereof, is a major factor influencing the healthcare decisions made at the U.S.-Mexican Border.

Capitalist medical systems where patients are turned away due to their lack of ability to pay for services or medicine (forcing them to cross borders to access affordable medical resources) is often criticized in comparison to socialized medical systems where health is often viewed as a guaranteed human right. Thus, refusing healthcare access due to an inability to pay could be considered a human rights violation by some rather than a justification for paying for the production of such healthcare “commodities.” As soon as these practices and items are exchanged or sold they become commodities. This raises the issue of whether healthcare and resources should be conceived of as commodities to be bought and sold, or if we should conceive of them as something that should be assured by society for all. Merrill Singer explains:

...the entire pharmaceutical industry rests on an unquestioned acceptance of medical commodification; rather than a basic survival resource in which people have an inherent right, manufactured medicines (although often made of naturally occurring substances or having their origin in indigenous healing practices) are the private property of the pharmaceutical companies – or in the case of patents, their intellectual private property – access to which is governed by ability to pay. Since profit is the bottom line, continuously expanding production is highly valued. All markets are good markets, and when possible, establishing new markets is the name of the game (Singer 2008:139).

Critical Medical Anthropology (CMA) (discussed below) looks at the “supply and demand” of these commodities within the political economic structures of the societies, countries, and markets in which they are available (Singer 2008:6). This is building on the works of Sydney Mintz and Eric Wolf who argue that society makes commodities and commodities make society in return (Mintz 1985, Wolf 1997 [1982]). Sydney Mintz provides an example of how dependency theory and commodity fetishism can be used to elucidate the global and historical contexts of sugar production. Meanings of sugar

trickled down from the “dominant” classes to the working classes, thus providing certain “norms” and models (1985:174). These meanings were linked with working class life structures and patterns. As Mintz states, “sucrose was one of the people’s opiates, and its consumption was a symbolic demonstration that the system that produced it was successful” (Ibid. 174). Differential consumption patterns also reflect “wider processes” connected to new notions of time, workday structure and statuses which are further indicated through direct and indirect consumption of sugar (i.e. processed foods – available at higher cost and lower time investment) (Ibid. 195). He concludes that “diet is remade because the entire productive character of societies is recast and, with it the very nature of time, of work, and leisure” (Ibid. 213). Sugar was one of the first items within capitalism that conveyed the complex conception that “one could become different by consuming differently” (Ibid. 185). Healthcare commodities also reflect that dialectic interchange between shaping and being shaped by the structures and populations they are found in, just as individuals are in dialectic exchange with the structures that surround them. Where one consumes healthcare therefore will shape and/or reflect one’s identity, status, ideology, etc. As Mintz states, “in understanding the relationship between commodity and person, we unearth anew the history of ourselves” (Ibid. 214). One of the most important concepts from Mintz’s work for understanding cross-border healthcare at the U.S.-Mexican Border is that items such as sugar or medications are multiple functioned artifacts which are culturally defined commodities (their meanings come from their multiple functions – for medications these include healing, curing, reducing risk, increasing health, function and longevity, controlling sickness, controlling behavior,

controlling ideologies, making money, supporting new research and jobs, possible abuse, overdose, death, etc.)

Eric Wolf also shows this connection between commodities and social constructions on a global scale in his piece Europe and the People without History. As he attempts to reclaim history for those who were left out of the ‘official’ historical reconstructions, he shows the global interconnections of commodity production and consumption patterns on multiple geographical and cultural sites. For example, in his chapter on the Industrial Revolution he examines all of the contributors to making cloth, including the markets for the raw materials, immigrant laborers for the factories, cottage industries for the local populations, its affect on the slave trade and its link with colonialism. This approach is excellent at presenting the ways in which the world is politically and economically interconnected. It also shatters the conception that cultures or groups are static, bounded, or isolated. The idea that a group can act without affecting other groups is challenged, especially within a capitalistic mode of production model. The role of power, ideology and hegemony is also evident in this analysis.

In examining Native Hawaiian health, and drawing on Paul Farmer’s work (1999, 2003) Juliet McMullin explains “exposing relationships of structure and power illuminates the ways in which the social structure (including cultural, institutional, political, and economic ideologies and practices) constrain Native Hawaiian agency, hindering individuals and groups acquiring healthy foods and accessing healthy environments” (2009:10). Adding perspectives from Galtung and Foucault she points out, “the effect of this systematic constrained agency is a type of violence that ultimately

kills people through neglect” (Ibid.). These same constraints are attempted through the ‘risk’ campaigns mounted by U.S. media and medical institutions about the dangers of cross border care in order to deter U.S. residents from crossing into Mexico for healthcare. Therefore, knowledge as a social construct that wields power becomes a commodity of its own as groups like the TMCs seek out those who have accessed services in Mexico before to find out how to safely follow in their footsteps. The pressure for them to seek healthcare overrides the pressure from the U.S. institutions ‘warning’ them away from the nebulous, margins where U.S. control is weak or absent. Knowledge of the ‘unknown’ marginal area that is the border can then become power in the hands of the border crossers accessing their care in Mexico as they learn the system and the practice – this will erase the fear of the ‘unknown’ as knowledge replaces mystery and mythology allowing them another avenue to access their life sustaining resources. Thus power is not only in the hands of the elite, power is also in the resistive practices of the individuals in the middle and at the bottom of the class hierarchy.

Dependency, world systems, and articulation theories (Wallerstein 1974; Gunder Frank 1966, 1996; Wolf 1997 [1982]; Kearney 1996, 2004) provide insight into the uneven macro-level relationships between the United States as a 'core' nation and Mexico as a 'periphery' nation. A deep understanding of history is necessary to contextualize these relationships as they are not static, instead, they change as shifts in political economic events and policies occur. Wolf explains that, "what attention to history allows you to do is to look at processes unfolding, intertwining, spreading out, and dissipating over time. This means rethinking the units of our inquires — households, localities,

regions, national entities — seeing them not as fixed entities but as problematic: shaped, reshaped, and changing over time" (2001:390). These three theoretical perspectives bring in the history of capitalist development on a global scale to understand the political economic connections between cores and peripheries through time. This is particularly relevant when examining the U.S.-Mexican Border as it is a space of intertwined histories from both nations as they shape, reshape and change each other over time; for the border both divides and binds these two countries (see Chapter 1).

The economist Andre Gunder Frank used the history of capitalist processes to challenge the idea that development and under-development were separate phenomena and suggests that one was the result of the other. As capitalism spread across the globe, it penetrated into peripheral spaces which consequently became "dependent satellites of the metropolitan center" (Wolf 1997 [1982]:22). The key idea was the process of capital accumulation acting as the driving force of world system history (Gunder Frank 1996:42). He argued that through the extraction of surpluses from these satellites to meet the needs of the metropolis, capitalism created a process of under- or de-development of the 'satellite' areas by the 'metropolitan' areas (Wolf 1997 [1982]:22, Gunder Frank 1966:23). Frank called this the "the development of underdevelopment" and it became known as dependency theory (Gunder Frank 1966, 1996, Wolf 1997 [1982]:22). This perspective is important in analyzing the relationships between Mexico and the United States, which are greatly manifested at their shared border. Mexico was a colony of Spain and has been struggling to break out of its periphery status ever since with the United States, which is positioned as a core nation. Frank explained that "these metropolis-

satellite relations are not limited to the imperial or international level but penetrate and structure the very economic, political, and social life of the Latin American colonies and countries" (Gunder Frank 1966:20). Furthermore, the greatest times of development in the satellites occur when they are in a weak relationship with the metropolis (Ibid.24).

For example,

[the] most important recent industrial development — especially of Argentina, Brazil, and Mexico, but also of other countries such as Chile — has taken place precisely during the periods of the two World Wars and the intervening Depression. Thanks to the consequent loosening of trade and investment ties during these periods, the satellites initiated marked autonomous industrialization and growth (Ibid.)

Furthermore, once the metropolis recovers from its crisis, the satellite is brought back under the control of the metropolis, cutting off the previous growth, or redirecting it into "directions which are not self-perpetuating and promising" (Ibid.24-25). In addition, Gunder Frank did not agree with other scholars that transnational corporation investments were the cause of dependency relationships or that dependence would be diminished or eradicated if, or when, they were replaced by foreign loans and bank debt (Gunder Frank 1996:34). He explained that, "the new debt crisis certainly proved them wrong. It vastly increased foreign dependence, even of 'sovereign' national states. Their trade, monetary, fiscal, and social or 'development' policies are even more constrained now by foreign debt than they were before by foreign investment" (Ibid.). Mexico's economy can experience a financial boom by providing affordable medical care for U.S. poor, elderly, un- and underinsured. Once a program of national healthcare is put into place this practice could be unnecessary and this would result in the loss of this economic opportunity for Mexico and the Mexican healthcare industry. This also plays into the

negative stereotypes used by U.S. interests to scare people away from Mexico as a site for healthcare as it is presented as “unregulated” and “dangerous” against the vision of the United States as “safe,” “clean,” and with a top-notch healthcare system that everyone wants to use. Additionally, there is the implicit assumption that the U.S. medical system is better than that in Mexico thus, U.S. nationals would not choose the Mexican medical system over the U.S. one and Mexican nationals would naturally choose the U.S. system over theirs if they could. Interestingly, this turns out to be an erroneous assumption (see chapters 3 and 5).

Immanuel Wallerstein examined the historical origins of capitalism or the "European world-economy" during the 15th and 16th centuries as an example of world systems theory since, "capitalism as an economic mode is based on the fact that the economic factors operate within an arena larger than that which any political entity can totally control" (Wallerstein 1974:230). He explained that, "a world-system is a social system, one that has boundaries, structures, member groups, rules of legitimation, and coherence. Its life is made up of the conflicting forces which hold it together by tension, and tear it apart as each group seeks eternally to remold it to its advantage" (Ibid.229). Market growth on a global scale, along with the resulting uneven occupational and geographical global division of labor, created the basic differentiation between the cores and peripheries that are connected through profits, surplus production, unequal exchange and exploitation of the peripheries by the cores (Ibid.231, Wolf 1997 [1984]:22). The key to this system was capital accumulation in a cycle of gains and losses played out between spaces in which a gain in one equaled a loss in the other (Wallerstein 1974:238).

However, "this is not quite a zero-sum game, but it is also inconceivable that all elements in a capitalist world-economy shift their values in a given direction simultaneously. The social system is built on having a multiplicity of value systems within it, reflecting the specific functions groups and areas play in the world division of labor" (Ibid.).

Wolf explained that Wallerstein's and Frank's theories replace "...the fruitless debates about modernization with a sophisticated and theoretically oriented account of how capitalism evolved and spread, an evolution and spread of intertwined and yet differentiated relationships" (Wolf 1997 [1982]:23). One of the most important contributions of this work is the conception of the world as interconnected through modes of production and consumption and as fluid rather than bounded, isolated and/or static entities existing independently of one another. Dependency and world systems theory, as outlined by Wallerstein and Gunder Frank, set the stage for articulation theory as they illuminate the relationships between capitalist and non- or pre-capitalist modes of production in a symbiosis of perpetual cycles of development and de-development in the pursuit of capital accumulation. Articulation theory moved beyond the polarized notion of developed and underdeveloped spaces by focusing on modes of production and the way in which they `articulate' within diverse configurations to form a complex interrelationship within a capitalist system (Kearney 1996:81-82). It suggested that when non- or pre-capitalist and capitalist economies come into contact they transform each other rather than one subsuming and overtaking the other (Lewellen 2002:65). For instance, capitalist cores depend on the peripheries to provide them with labor (re)production, raw materials and a market; additionally, the non-capitalist peripheries

depend on the cores for wage labor to subsidize their non-capitalist modes of production (i.e. subsistence farming) and basic commodities. Through this interconnection, the cores receive the needed materials for their production activities while the peripheries receive a means to meet their subsistence needs, which in turn (re)produces the labor needed by the core. This challenges the notion that capitalist penetration of non-capitalist modes of production would eventually lead to their eradication and replacement with capitalist modes. Instead, this theory suggests that capitalism depends on its articulation with these other modes of production (Kearney 1996:84). Therefore, "...conditions of persistent underdevelopment noted in the 1970s implied that such articulations were not transitional but were inherent in capitalism as a global system" (Ibid.84-85). Interestingly, this articulation between peripheries and cores produces a global class stratification model existing between nations rather than within them. Thus, Marxist analysis of their interconnected and conflict-ridden relationships becomes more pertinent. It is important to note that the dependency mentioned above is not a one way process of peripheries being dependent on the cores; rather, the cores are just as dependent on the peripheries, even though they have more power to push their advantage. Thus, in addition to an articulation of modes of production, there is also an articulation of dependencies, though these are certainly uneven.

Migration is brought into the equation as a way in which non-capitalist labor is incorporated into capitalist modes of production across great distances, including national borders (Kearney 1996:83). For example, farm laborers are structurally and socially 'reproduced' in Mexico (the periphery) to meet the needs of industrial agriculture in the

core (the United States). Additionally, this labor is often commodified as a resource to be used and discarded when all possible surpluses have been extracted. Therefore, labor migration across borders benefits the receiving nation (the United States) as the cost of labor reproduction has been born by the sending nation (Mexico) thus, lowering the economic 'cost' of labor reproduction (i.e. education, housing, food, etc.) for the receiving nation. This is also a detriment to the sending nation as they have invested in the 'production' of this labor and do not receive the benefits of it (when remittances are brought into the equation, then a partial benefit of this labor production is recognized in the sending nation) (Kearney 2004). Thus, articulation of labor occurs between nations through the production of labor in one space for its use in commodity production in another. Additionally, if these laborers continue to use medical services in Mexico rather than in the United States, then their economic worth in relation to their production and reproduction in the United States would rise since the cost of keeping them healthy and productive would be borne by Mexico. Therefore, transborder healthcare is a subsidy of the United States as it shifts medical and health costs across its borders into Mexico. Furthermore, economic pressures of the high cost of healthcare procedures and prescription medications, along with the lack of medical insurance coverage for many people in the United States, create markets across the border in Mexico for services and affordable healthcare for economically vulnerable U.S. populations. They also create a great source of revenue for Mexican border towns that have often relied on providing tourist services such as restaurants, bars, and shopping for their economic base. For example, U.S. tourists used to go to the small town of *Los Algodones* located

approximately 11 miles west of Yuma with a population of about 10,000, to “...gamble, drink and eat at the town’s cantinas or visit the brothels” (Medd 2002). Today, a California newspaper paints a different picture of *Los Algodones*. The following is an excerpt from a newspaper article in 2002 describing this small town:

Sunlight pierces the morning shadows as Victor ‘Tino’ Lara mops the pavement of a small plaza surrounded with medical offices. Bright green planters accent single story buildings painted burnt orange, sky blue, purple and violet. A short stroll away, Alicia Alvarado arranges cheap silver jewelry on a folding table in Callejon Alamo, a walkway lined with street vendors and shops. It’s another workday in a border town that has reinvented itself from a Mecca for pleasure – seekers to a haven for Americans looking for a doctor, a dentist or a pharmacy (Ibid.).

The income generated in Mexico by those crossing the border for care also adds value to the Mexican economy when U.S. citizens access the lower cost care in Mexico. Conversely, when middle and upper income Mexican citizens access care in the United States they add value to the core and subtract it from the periphery. Additionally, profits for U.S. insurance companies rise when they support their clients in receiving less costly care in Mexico rather than in the United States which adds value to both the core and the periphery. Thus, a dialectic between sustaining health in individuals and investing in health conferring resources is formed. Gunder Frank’s observation of shifting values, mentioned above, adds to this analysis. For example, if profit from healthcare entities such as hospitals, insurance companies and practitioners (including technology) is reinvested in these domains, then any profit "lost" to another system slows growth in the first while contributing to growth in the second and vice versa.

It is easy to see that there is a complex mix of tourism as commonly conceived and practiced and transnational healthcare relationships between patients and providers.

The idea is the same, providing services for a population so that they will come and spend their money in one locale rather than another. However, the small town of *Los Algodones* is not creating the circumstances for the market; rather the town's providers are filling a need. This is highly political due to the tensions created by economic need of patients and the medical markets in both Mexico and the United States competing for their business. In the United States medical care costs have made access difficult for many people. Insurance can help people meet the rising cost of medical care, but even insurance companies are offering cross-border care plans to reduce their costs. Several companies, including Blue Cross, offer lower premium plans for people who will obtain their healthcare in Mexico rather than in the United States. They often reduce the co-pay from 10% of the procedure to \$4.00 or free (full coverage) for those choosing this option (Mena 2002; Berestein 2002).

Furthermore, when U.S. citizens go to Mexico for healthcare, this shifts the potential profit away from U.S. pharmaceutical companies to Mexico which means an economic benefit for that country and a loss of profit for the U.S. healthcare industry. As a result, the Federal Food and Drug Administration (FDA), the U.S. Department of Human Health and Services (DHHS) and U.S. pharmaceutical companies are warning consumers that buying their medication or seeking their healthcare in Mexico is risky and dangerous because they do not have the same regulations as are in place in the United States (Mena 2002:B1, FDA 2005, FDA and DHHS 2004). The manufacturing of the drugs is also questioned. This type of proclamation is used in an attempt to hold people back from participating in cross-border care. However, since the populations accessing

resources in Mexico cannot afford them in the United States one could argue that the pharmaceutical companies actually gain more profit from this practice since they receive some profit from their sales to Mexico and they would not receive any profit if the populations did not buy their medications at all, rather than across the border. It is a positive shift for seniors, poor, and the uninsured and underinsured with a possible negative of higher risk for them (safety issues). Additionally, in the case of cross-border healthcare access at the U.S.-Mexican Border, the core (United States) depends on the periphery (Mexico) to provide low cost/affordable healthcare for marginalized populations and the periphery depends on the consumers from the core for the profit value they bring. Additionally, this shift of value benefits the core by helping it to maintain its present exclusionary “for profit” healthcare system. The fact that elderly and poor U.S. citizens can cross the border into Mexico to access more affordable healthcare allows the healthcare industry in the United States to maintain their higher prices. This practice acts as a pressure valve allowing those who would put pressure on the industry to accommodate them to independently find a solution to their problem or to adjust the market price to reflect the actualities of the supply and demand for these health commodities. This also connects with the ideology of ‘independence’ and individual responsibility for one’s circumstances rather than seeing the institutions that create and maintain those individual circumstances as involved in this process. It is tantamount to ‘blaming the victim’ if they fail to access resources. Additionally, since they are able to access resources in Mexico their suffering is somewhat alleviated, thus, alleviating the pressure they feel by not being able to access these resources here in the States. I argue

that this hegemony of individual responsibility removes the incentive for people to demand satisfaction from the institutions that are causing them the problem in the first place since the exclusion of access is not dealt with or seen as a systemic problem, but rather a personal one. Individual agency is then brought into the equation rather than just focusing on the institutions that are shaping the context of healthcare in the United States; these individuals are also shaping this situation through their actions and acceptance of the system (or that they cannot change the system, so they find other ways to meet their needs, such as crossing the border to gain access in another one). They feel that they are being independent and taking care of the situation themselves, but they also feel that the institutions are greedy companies that they cannot control. It also relieves them of feeling that they are “victims” of the “out of control,” “greedy,” profit mongering pharmaceutical companies or burdens to their families or society since they cannot take care of the medical needs without this strategy. This provides insight into how political economic structures can attempt to obstruct human agency and how hegemonic notions become ‘real’ for the populations in society.

The Political Economy of Health and Critical Medical Anthropology

Medicine is often thought of as objectively scientific dealing with healing and separate from other cultural components; however, medicine as a discipline and practice is a highly political cultural construct. Health and medicine are resources and as such are subject to the same political economic processes of accumulation and allocation as other resources. It is “...filled with power struggles and efforts to control individuals or social groups” just as other political institutions (Baer et al 2003:8). Therefore, it is important

to locate medicine and health within the capitalist world system using a political economic approach as critical medical anthropologists do.

Using a political economy of health approach from critical medical anthropology (CMA) provides tools for analyzing aspects of health risks and strategies in the U.S. – Mexico Border region and how they are embedded in global, transnational contexts (Doyal 1979; Navarro 1976; Baer 1996; Singer 1996, 2001, 2003; Farmer 1999, 2003; Scheper-Hughes 1992). The political economy of health attempts to understand the larger ‘invisible’ structures and ‘causes’ in relationship to health, healthcare and intervention programs that are naturalized and normalized through national ideologies. Asymmetrical political economic relationships and positions within and between the United States and Mexico are reflected in health risks and strategies at the U.S.-Mexican border. The connections between health, medicine and class structures in the U.S.-Mexican border area are also reflective of these relationships between and within these two countries. Health is therefore a multifaceted state that concerns more than the biological condition of a person, encompassing social, ecological, political and economic factors as well. Understanding how this relates to Mexican and U.S. populations within the U.S. – Mexican Border region is important since many of the border cities experience high rates of poverty and thus, higher rates of morbidity and mortality (Fairbanks 1997:73-74).

Critical Medical Anthropology (CMA)

According to Merrill Singer, “CMA is a scholarly and applied approach concerned especially with the political economy of health, including understanding the

social origins of sickness, health-related beliefs and behaviors, and healing systems and treatment practices” (Singer 2008:5). It is “concerned” with the power issues and inequality surrounding health. Rather than looking solely at the institutional level, CMA uses both macro and micro levels of analysis.

...it focuses attention on the relationships between on-the-ground (i.e., observable) health-related actions and the actors who perform them, as well as associated beliefs, attitudes, and experiences, on the one hand, and macro-level structures and forces, such as modes of production, social hierarchy, and hegemony, on the other. [This also includes]...factors such as social class and other structural relations, policies enacted and actions taken by state institutions, including court rulings, the enactment of laws, and the use of physical force through the activities of the police, national guard or other military bodies, and the social effects registered by the prevailing economic system (Singer 2008:5).

The historical development of this approach and the current outlook of the discipline are explained by Baer et al (2003),

The critical perspective we want to nourish and extend has its taproot in Marx, Engels, the critical theorists of the Frankfurt School and C. Wright Mills (1959). We are concerned with the ways power differences shape social processes, including research in medical anthropology. Like Navarro (1976), Krause (1977), Doyal (1979), Waitzkin (1983), and Foucault (1975), we feel that the dominant ideological and social patterns in medical care are intimately related to hegemonic ideologies and patterns outside of biomedicine (2003:37).

Studies in CMA view medicine, as an institution, through its connection to the capitalist structures and class relations. In a ‘for profit’ capitalist medical model, such as in the United States, differentials of morbidity and mortality are directly linked to the increasing differentials of wealth and income between the upper and lower classes. In such a class system, the upper classes typically will have greater access to health and medicine than the lower classes due to their greater accumulation of capital. Thus, class

is a socially created stratification and economically structured relationship that places certain groups of people "in harm's way" (Singer 2001:81, 86). Therefore, factors such as class, income levels and SES are significant in the production of 'health' contexts and need to be included in studies of health and access. In addition, health conceptions and medical hegemony are also part of the institutional aspects of class domination and subordination in the United States. Medicine as a part of science is a way to construct reality through the construction and interpretation of ideologies related to cause, cure, treatment, health, illness, disease, etc. These ideologies lead to certain behaviors being accepted as healthy and others as unhealthy or unsafe/risky. Those engaging in risky behaviors are then responsible for their ill health rather than the situations or the lack of access to 'safe' behavior that may push them into risky behavior.

Health risks and strategies for border populations are unique as they reflect the asymmetrical relationships between classes and nations occurring at the border. For example, the TMCs who go to Mexico for healthcare are perceived as doing something that puts their health at risk (by going into an area unregulated and uncontrolled by the United States medical system); however, if they did not do this strategy they would not be able to take their life sustaining medications, or get dental care or eye glasses which again would make them 'non-compliant' with their U.S. healthcare provider which could cost them their healthcare access completely (so if they did not access these items they would be seen as not following orders from their doctor and this could mean that their doctor could drop them from his practice and inform their insurance carrier – if they had one- that they were non-compliant which could allow the carrier to drop them or not

assign them another provider and all of this would be laid at the feet of the patient who could not afford the medical items recommended by the doctor). So it is not the doctor's problem if you cannot afford what he prescribes, it the individual's problem of how to access these items, and the conversation is often not "did you not take them because you could not afford these items?" rather it is "you did not take these things, now your health is worse and there is little I can do to help you." So the social, political and economic factors affecting the patient's access is glossed over and the only focus is on the individual's treatment plan and that person's failure to achieve it. This is equivalent to blaming the victim under the guise of healing a patient. Thus, science and medicine are embedded in other cultural factors such as politics and economics and these factors shape them as they shape these factors. Hence, medical care and hegemony are not 'objective,' 'scientific,' detached models without values, moral judgments and prejudices attached. Consideration of the socio-cultural aspects of disease and illness is a vital and fundamental element of critical medical anthropology and thus, of my work at the U.S.-Mexican Border as well (Baer et al 2003:38, 52, 54; Singer 2003).

The power that biomedicine has comes from its support from the "...capital class whose interests it commonly serves" (Baer et al 2003:13). Wealthy Americans funded medical schools that taught biomedical approaches to disease. "Biomedicine focused attention on discrete, external agents rather than on social structural or environmental factors" (Baer et al 2003:13). It was also expected to create and maintain a healthy work force that would add to capitalist profit (Ibid. 13). Medicine also produces its own profit through the 'discovery' of new diseases and responses to them (i.e. cures and/or

treatments). This is intimately tied to the process of ‘medicalization.’ This process “...contributes to increasing social control on the part of physicians and health institutions over behavior. It serves to demystify and depoliticize the social origins of personal distress” (Ibid. 14) by obscuring the structural violence committed by institutions in the name of profit and cost containment at the expense of the health of vulnerable populations. This process builds on the American ideologies of individual responsibility and independence to make health an individual matter rather than a social one. Therefore, “underlying the medicalization of contemporary life is the broader phenomenon of *medical hegemony*, the process by which capitalist assumptions, concepts, and values come to permeate medical diagnosis and treatment” (Ibid. 14, italics in original). As such, the doctors treat the symptoms of a stressful life rather than the social causes of the stressors which might eliminate the need for future treatment and result in a cure of the problem. Therefore, this treatment model allows the system to maintain itself since the medical industry offers some relief of the pain of living in a stressful environment which acts as a pressure release valve removing the need and motivation for change (or at least the perception of the need for change). (The pain is relieved so the situation can continue, so the medical industry is co-opted into the system as a mechanism for its maintenance.) Furthermore, those benefitting from the system as it is are then free to continue to benefit from it without alleviating the suffering of those who are not benefitting from the current system and may in fact be exploited and harmed by it. The ideological support for this practice (individualism and independence) further absolves those at the top from feeling any responsibility for those at the bottom and those

at the bottom will also believe that it is not their responsibility to help alleviate their suffering.

Navarro, following a political economic approach to health and setting the foundation for critical medical anthropology, found that several studies on healthcare consumption ignored class as a variable or suggested that in the U.S. government funded anti-poverty programs and Medicaid “...rendered class differentials in medical care consumption a thing of the past. And if any differences do exist, they are more likely to be skewed in favor of the lower than the upper echelons of our social spectrum” (Navarro 1976:185). This conceptualization renders classes invisible within capitalist societies. They become homogenized into a blurred middle-class in which mobility and opportunity are open to anyone who desires it. An implication of this is that it is assumed that poverty and marginality are “both provisional and correctable” (Ibid. 185-6). In addition, Navarro analyzes how the State is implicated in class relations. He points out that much of State control is in the hands of the elites from the upper class strata of society. Thus, the State is directly controlled by those with the most resources, the capitalist, bourgeoisie and upper classes (Ibid. 189-190; 1993:11). Medicine as an aspect of the capitalist State has also been controlled by these classes (1976:205) and contributes to a ‘healthy’ economy through keeping the proletariat ‘healthy’ and productive, as well as creating a medical hegemony of personal and individual conceptions of health and medical treatment in which the environmental and structural components of illness and disease are obscured. Navarro explains that

indeed, a historical, empirical, and political analysis of the health sector indicates that (a) the most predominant force in determining the nature of

medicine and the resulting iatrogeneses and dependencies has been not the medical profession, but the capitalist system and the capitalist class; (b) for the most part, medical professionals are the administrators and not the creators of these dependencies; and (c) this interpretation of bureaucratic and professional power and control leads to a strategy that ultimately strengthens the ideological construct of capitalism (Ibid.:191).

Therefore, it is crucial to critically examining the importance of class as a political economic factor in the U.S. healthcare system as one of the ‘power categories’ like race and gender (Navarro 1993:12). Navarro also explains that capitalism is the driving force behind our medical institutions by controlling the funding and delivery of U.S. healthcare (Ibid.:11). As a result, it is essential to understand how policymaking and the state are influenced by classes and the political and economic institutions in which they are embedded (Ibid.:83).

Merrill Singer explores how class and social inequality is linked with medicine (2001). He explains that, “inherently, the biomedical model tends to lend itself to the development and perpetuation of stereotypes that legitimate oppression in national and global situations because it narrowly locates the causes of ill health in the actions and organs of suffers” (2001:78) rather than in political economic and/or social factors such as poverty (Ibid. 78-9). Thus, the “political roots of disease” are obscured as the cause of illness is attributed to “choices” made by individuals, such as not taking medications that they can’t afford, or not seeing a doctor that they can’t afford (or will give them a diagnosis that will preclude them from getting insurance later due to a ‘pre-existing’ condition), or seeking “risky” care in Mexico where they can afford it, without examining the political economic reasons for the lack of access to healthcare resources (Ibid:79). As such the biomedical model is not recognized as a socio-cultural creation which acts as an

interpretative model of the “physical world” (Ibid. 80). It is vital to note that, “...the higher rates of morbidity and mortality commonly found among the poor and the oppressed reflect patterns of social inequality and unequal access to health-conferring resources rather than failed adaptation to natural environments” (Ibid. 81) or “bad choices” made by individuals.

Baer et al break healthcare systems of capitalist and “socialist-oriented” societies down into four levels of analysis with corresponding “social and biopsychological relations” (2003:39-51). The levels with their relations are as follows: 1) Macro-social (capitalist world system, corporate and state sectors, plural medical systems, cosmopolitan medicine, Heterodox/ethno/religious medical systems and health institution policy/decision-making); 2) Intermediate social (health institution policy/decision-making, and administration – health personnel interactions); 3) Micro-social (interactions among health personnel, physician-patient interaction and healer-patient interaction); and 4) Individual (patient’s personal support network, patient’s experiential response to illness and human psychobiological system). These levels reflect and reproduce the class system in capitalist societies. Furthermore, “the profit-making orientation caused biomedicine to evolve into a capital-intensive endeavor heavily oriented to high technology, the massive use of drugs, and the concentration of services in medical complexes” (Baer et al 2003:40).

For my work on transnational healthcare at the U.S.-Mexico Border, this means looking at the micro-level of individual agency in the people who cross the border to access healthcare, how and why they do it, their beliefs and reasons for doing so, the

economic and insurance issues surrounding their decisions and their health outcomes with the practice. The relationship of the practice to the hegemony and counter-hegemony of both nations is essential to understanding it. My work also necessitates looking at the macro-level of institutional responses to this cross-border practice, including how insurance companies, the FDA, DHHS, the U.S. Border Patrol, congress, laws, the pharmaceutical companies, medical practitioners, the media and the medical establishments on both sides of the border react to these cross-border practices by the individuals, in the context of what Singer calls “Global Drug Capitalism.” This refers to how drugs are made in one country, sold in several by corporations headquartered in another; thus, they are true transnational companies (Singer 2008:10, 11). In examining this phenomenon through a CMA approach I am hoping to move toward the goal of contributing “to the larger effort to create a new health system that will serve the people” (Baer et al 2003:51).

Nancy Scheper-Hughes in her work on hunger, poverty and mothering in the Brazilian Alto, uses a CMA approach as she builds on Pablo Freire’s concept of “action based on critical reflection” that takes empirical ground level information and critically questions the assumptions and normalizations present such as “whose interests are being served?” and “Whose needs are being ignored?” (1992:170). An important insight is that “commonsense reality may be false, illusory, and oppressive” or socially constructed to serve the purposes of those in power over those who are not (1992:171). Critical theory then attempts to strip “away the surface forms of reality to expose concealed and buried truths... [and] to ‘speak truth’ to power and domination in individuals and in submerged

social groups or classes” (1992:171). Her critique continues in the realm of ideology and hegemony which are seen as obscurers of power relations and domination; thus, acting as, in the words of Marx, the ‘opiates of the masses.’ They are also used to “sustain, legitimate, or stabilize particular institutions or social practices” (1992:171). Gramsci’s concept of hegemony is linked with power, institutions and knowledge production which is used to support existing structures of order and ‘commonsense’ (Ibid. 171).

Anthropologists and biomedical providers and practitioners can be co-opted into sustaining the status quo through their assumptions and naturalizations based on their enculturation into certain systems (Ibid. 172). Merrill Singer expands on this concept by explaining that

Social injustice, in short, is not merely a product of indifference and ignorance on the part of those who benefit from it, nor is it created and maintained by the moral, attitudinal, or behavior deficits of those who suffer from it. Rather, it is an arrangement that materially benefits some while harshly punishing others. The extent, nature, and causes of inequality in America are hidden, not just by the mass media and other mainstream social institutions, but by a set of hegemonic ideas about people and their personal responsibility for individual success and failure. Many Americans believe that poor people have no one to blame but themselves because they do not work hard; they do not plan for the future; they do not value education; they have too many children; they come from bad families that do not parent properly; they suffer from some other moral, social, or personal shortcomings, including the use of drugs (Singer 2008:17).

Poverty and social inequality perpetuate and maintain the system; they are not the unfortunate and/or unintended consequence of it (Ibid. 15). Levy and Sidel as quoted in Singer elucidate these connections

Social injustice often occurs when those who control access to opportunities and resources block the poor, the powerless and those otherwise deprived from gaining fair and equitable access to those

opportunities and resources. Social injustice enables those in the upper class to receive a disproportionate share of wealth and other resources – “the good things in life” – while others may struggle to obtain the basic necessities of life (2006:11) [quoted in Singer 2008:15].

This is structural violence (Farmer 1999, 2003).

Discourses on health place how we think about healthcare, responsibility, access and choice in particular contexts and directions and at the same time not in others. Denying poor and elderly populations healthcare is “bad” and would make healthcare institutions, including pharmaceutical companies, look “bad” but individuals making “risky” choices to save money is on the individual and the institutions are “good” because they are warning them of the dangers (which obscures the fact that they put these individuals in the position to have to make those ‘choices’ through their creation and control of the health for profit marketplace context for U.S. healthcare). Thus, medicine and disease conceptions become aspects of social control and hegemony of the State over those oppressed by its system. Symbols of independence, individual responsibility, distrust and dislike of government and bureaucrats, Mexico as a “cheap” shopping opportunity all push U.S. consumers into Mexico for healthcare services that they cannot access in the same way in their home nation.

Transnationalism

The concept of transnationalism also offers insight into the micro-level relationships between, and within, local populations at the border and how these articulate with macro-level border health contexts. Migration, within a context of dependency and articulation, has emerged in new ways. For example, “... what common people have done in response to the process of globalization is to create communities that

sit astride political borders and that, in a very real sense, are 'neither here nor there' but in both places simultaneously" (Portes 2000:254). These simultaneous communities are transnational and based on cyclical movement between the sending and receiving countries (Ibid.:259-60). The fluid and continual movement of local populations at the border form the mechanisms for building and maintaining extensive social networks. Border populations, including TMCs (see chapter 3) constantly shift members, locales, and employment to adapt to their social positions as economically marginal and/or vulnerable populations. Ted Lewellen explains that a transnational migrant is "... one who maintains active, ongoing interconnections in both the home and host countries...these relationships may be economic, social cultural, or political" (2002:151) and are often all of these simultaneously. The degree of contact with the home country is variable and consists of phone calls, remittances, travel, participation in community events, and as I have documented, also healthcare (Ibid.:151). Transnational populations break through the traditional concepts of bounded territories and create a new type of unbounded community located in what Lewellen calls "deterritorialized space" (Ibid.:151). It is a "social space... defined in terms of social networks" rather than national boundaries (Ibid.:151). Lewellen lists five characteristics of contemporary transnationalism as applied to South Africa by Jonathan Crush and David McDonald. These characteristics also apply to communities in the U.S.-Mexican Border area. They are as follows:

First, 'lives are lived across border' with a high intensity of ongoing social and economic interactions made possible by cheap and rapid travel and by instantaneous communication. Second, transnationalism is a fairly recent effect of the flexible job market made possible by the internationalization

of capitalist production and finance. Third, transnationalism creates a novel type of migrant identity, a hybrid combination of both home and host, requiring that researchers develop new methods and new concepts to examine identity. Fourth, over time transnationalism becomes increasingly independent of its original conditions, as migrants gain knowledge and acquire cultural capital and social networks are reformulated and expanded. Finally, transnationals develop new modes of resistance — diaspora communities, interstate institutions, support networks and political power — to defend against their minority status in the host country and against asymmetries in the global marketplace (Ibid.:152).

For transnational medical consumers (TMCs) such as the snowbirds, day and weekend crossers, and tour bus patients who cross into Mexico for less expensive medicine, dental care and eye glasses the transnational networks referred to by Crush and McDonald mitigate some of the risks of accessing healthcare in an unfamiliar system and provide a mobile community both inside and outside of the United States. Relatively “cheap and rapid travel” along with “instantaneous communication” through cell phones promote cross-border healthcare for these populations. The “internationalization of capitalist production and finance” has resulted in medical products being available outside of the United States in familiar contexts that increase the confidence of the consumers in their products (i.e. name brand medication). As these populations gain experience in accessing these medical resources in Mexico they gain “cultural capital” that they share among their “social networks” which in turn expands the communities of those practicing cross-border healthcare. Perhaps the most interesting connection is seen in how their cross-border networks and practices are developed as a “mode of resistance” in response to the “asymmetries in the global marketplace” of healthcare as well as to the hostile medical environment they find themselves dealing with in the United States. This resistance is critical to their survival since they do not have the economic resources to access their

necessary and desired healthcare under the “for profit” healthcare model operating in the United States. That the medical industry should make a profit as all other businesses/industries, seems to be unquestioned by the institutional hegemonic forces shaping healthcare delivery and access in the States. Additionally, the discourses surrounding implementing a nationalized plan as other industrial nations have is steeped in the negative rhetoric of “socialism” and “un-American,” even “unpatriotic” as this is seen as going against the capitalist structures that have mythically built this nation and will lead to reduced profit for the healthcare industry. Thus the institutions are rallied around and protected so that they do not “die” by going out of business rather than the vulnerable populations who could literally die if they do not receive care. This provides as example of the structural violence examined by critical medical anthropologists such as Paul Farmer (1999, 2003).

The populations discussed above are not the only transnational part of this picture. The drug corporations are also transnational. Merrill Singer provides the following quote to explain this phenomenon

Adds Mehrabadi: Pharmaceutical/biotechnology companies cannot be pinpointed to one location as they function as any transnational corporation would: globally. As with any corporation that is transnational in scope, operations are carried out depending on where labor is cheapest, raw materials are the least expensive, where taxes can be most easily evaded, as well as where market regulations are the least strict. (2001:1) [quoted in Singer 2008:11].

Furthermore, the drug corporations “...use advanced communication and shipment technologies to spread their products around the world, rely on specialized branding and targeted packaging to make their products appealing to diverse consumer populations,

and mobilize considerable amounts of capital to gain access to new markets worldwide” (Singer 2008:15). These transnational pharmaceutical companies also respond to the different economies of each of their national “customers” by adjusting their pricing to maximize their profit in each market. This results in lower costs for medications in socialized medicine countries (SMC) such as Canada and Mexico, and higher prices in non-socialized medicine (pay for service), capitalist countries like the United States. SMCs buy in bulk for their whole country, which provides them with great bargaining power and results in much lower costs than in capitalist countries where individuals, insurance companies or drug distributors buy in smaller quantities and thus, have less bargaining power and pay a higher price for the medications. For instance, in the United States there is high competition among insurers, pharmaceutical drug distributors, individual consumers, but they buy in smaller quantities so the price is higher than the ones bought in extreme bulk by the countries. Furthermore, pharmaceutical companies have less power to charge higher prices to countries that are purchasing their drugs due to market place competition and the fact that if they charge too much the country will just not buy from them, thus they will lose that market and the large profit that they represent.

A university professor in Mexico explained that every year or two a “competition” is held by the Mexican government with the pharmaceutical companies. The companies compete with each other to be the one with the best quality drugs for the lowest price. Those companies “win” a contract with the whole country of Mexico for those drugs which provides a large windfall for the pharmaceutical company, and a good price for the country to supply their population with needed medications. Moreover, if

the company tries to pull a “bait and switch” with Mexico by ‘running out of’ or not able to produce the cheaper medication and tries to replace it with a more costly substitute (expecting Mexico to pay more for it – thus increasing the profit for the company and costing Mexico more for their healthcare) they are banned from the competition for 2 to 5 years. So, companies are less likely to risk losing this large market with those tactics. The competition and buying in bulk reduce the cost of the medicines and make it more affordable for Mexico to provide them for their people. Mexico, as a SMC is not selling the drugs for profit to their own people, but rather using them to heal the Mexican people. However, this system makes it possible for Mexican distributors to sell the medications on the open market to U.S. and Canadian consumers who cross the border for a fraction of the cost they would pay in their respective countries (see chapter 3 for examples). In the United States access to drugs is based on money and insurance coverage. The sale of these drugs is for profit, or at least to avoid losses for production for pharmaceutical company, and to fund further research for new drugs (or at least that is the ‘party line’). Low income consumers in this ‘for profit’ market can’t afford the drugs or insurance coverage, so they cross the borders to SMCs in the north and south to get them more affordably; thus, cheaper supply meets demand for cheaper medications at the border.

These global drug markets along with economic constraints (or lack of resource access) results in the push/pull of consumers in response to medical needs that pushes the poorer patients into markets where they can pay less for their medications; thus, as we see above making the patients transnational as well. These same transnational economic pushes and pulls are present in the creation of new medical markets for those who cannot

afford to access their care in their home country. For instance, *Los Algodones* became the “Mecca of Medicine” by providing the services, such as pharmaceutical drugs, needed by the TMCs, including lower prices and English speaking workers to attract that particular market of potential transnational consumers. Therefore, as discussed above (in the articulation section), medicine and healthcare can be perceived as a “value” or “commodity” to be shifted between the core and periphery where the periphery can offer care at a rate that is more affordable for those from the core with less economic resources. This does not mean that the institutions in the core look at this shift as positive. Instead, many see it as a loss of profit and thus create a discourse of fear and risk designed to keep people out of Mexico and in the United States (see chapter 5). This is a way the medical institutions attempt to “discipline” the border crossing populations (Foucault 1995 [1977]) and keep them in the purported “safety” of the United States system.

This reflects the type of social control medicine and healthcare institutions, ideologies and practices can wield within a capitalist system in the name of being ‘helpful’ and ‘progressive’ as described by Navarro, Singer and Scheper-Hughes (Navarro 1976, Singer 2001, 2008, and Scheper-Hughes 1992). It also reflects the notions of danger, purity and ritualized incorporation of the margins into the center as discussed by Mary Douglas in *Purity and Danger* (1966). Medicine as a State controlled ritual incorporates marginalized groups into the center where they become subject to State control and power. These ‘risk’ campaigns are designed to help the U.S. medical consumer make better, safer choices by keeping them in the country and out of the

uncontrolled regions of another country. Thus, the border crossing population can be seen as resisting these State forces with their medical choices. These populations are not static and bounded in their situations as poor, uninsured and underinsured; instead, they are in a constant dialectic with their positions/situations – accepting what they must while pushing when and where they can. Thus it is an interactive process between the institutions and individuals/groups which is dynamic and constantly shifting through the adjustments of both the structures and the people affected by, and influencing, them.

These practices also tie in with Foucault's notion of disciplinary influences of governmental institutions conditioning the behavior of those subject to its power as discussed in Aihwa Ong's piece on 'flexible citizenship.' Here she examines transnational populations with a political economic approach (Ong 1999:5-6). Her investigation of power relations between nations and transnational communities is useful to understand how individuals respond to the lack of resource access necessary to their survival and how the medical institutions respond to the loss of profit when U.S. residents cross into Mexico for their healthcare. Ong explains that, "these shifting patterns of [transnational] travel, and realignments between state and capital, are invariably understood according to the logics of culture and regional hegemony" (Ibid.6). This raises interesting questions about an area like the U.S. - Mexican Border that is inclusive of more than one hegemony and more than one culture. Another important argument made by Ong is that of flexible citizenship. She explains that flexible conceptualizations of citizenship and sovereignty (an idea that ties in with Lewellen's concept of deterritorialization) are necessary in a global economy so that "subjects" are able to

"respond fluidly and opportunistically to changing political - economic conditions" (Ibid.:6). She further suggests that it is not only individuals who respond to these new conditions of globalization, but also the State needs to "articulate with global capital and entities in complex ways" (Ibid.6). An additional idea related to my work is her examination of "U.S. - centered migration studies" which appear to view this topic only from a U.S. perspective that leaves out transnational connections and migrations (Ibid.8-10).

Ong explains that she shares Arturo Escobar's "critique of the Marxist code of signification" which presents markets, production and commodities as driving symbolic forces in the creation of "economic men and women" (Ibid.:16). Individuals and resources are then conceived of as separate entities brought together according market pressures. Ong views this as "essentializing and homogenizing" and as such needs to be left out of a political economic analysis. This is basically an argument over the absence of individual agency in the process of capitalistic production and that economics gains an importance that it may not deserve as the driving force of people's actions. However, in the case of healthcare access by those who cannot afford it in the United States, I think one can argue quite convincingly that economics, along with the belief that this healthcare is critical to one's survival or at least reduced suffering, is the driving force behind this transnational strategy. Furthermore, I think that the idea of hegemony is also important to this equation as it addresses why individuals may be 'co-opted' into the very market system that is exploiting them. Ong remarks that even in transnational contexts "political rationality and cultural mechanisms continue to deploy, discipline, regulate, or

civilize subjects in place or on the move" (Ibid.19). This statement is full of theoretical implications for my work at the border, especially concerning medicine as a potential 'disciplining' or 'civilizing' force.

Health can be conceived as a type of capital accumulation as those with “good health” are seen as “richer” than those with “poor health” both metaphorically and literally. Health also reflects actual capital accumulation as studies show that the “poorest white males in America die about a decade earlier than the richest” (Sapolsky 2005:76). While this is partially due to increased risks and a decrease in protective factors, it appears that chronic stress due to poverty has the largest impact on a person’s health (Ibid.). Thus, by not providing realistic and complete healthcare options for the poor, uninsured and underinsured, our nation increases their unhealthy state through an increase of their stress as they attempt to meet their health needs without adequate resources. This leads to situations where people may be contemplating whether to go without food or without medication when they can’t afford both. The ideology that health is important to have and is assumed to be important to have and maintain pushes against the question, “What price can you put on your health?” which pushes the notion that you should pay anything you need to for good health, for after all, “without your health, what do you have?”

Transnational Medical Pluralism

Medical pluralism is generally defined as the presence of two or more medical systems in one culture. This is often applied to situations where biomedical models are combined with ‘alternative’ models of health and healing providing multiple medical

choices for patients (Singer 2008). “From this perspective, *the* medical system of a society consists of the totality of medical subsystems that coexist in a cooperative or competitive relationship with one another” (Baer et al 2003:9, italics in the original). In these cases medical pluralism would be recognized as occurring at the institutional level with individual actors making their medical choices from the options provided to them by their cultural institutions. However, in my work at the U.S.-Mexican Border, I observed a different type of medical pluralism – one created by the individual actors as they crossed the border to use more than one medical system.

This pluralism is also different from ‘traditional’ definitions in that both medical systems accessed by these patients are considered biomedical models. (There are alternative models on both sides as well, but I only focused on the biomedical models that were accessed.) This brings an interesting dynamic to medical choice since in medical pluralistic systems patterns are inclined to reproduce the hierarchies in the larger society with biomedicine at the top and other modalities holding less status and power beneath it (Baer et al 2003:11; Singer 2003). Since both options are biomedical models this hierarchical model may be presumed to disappear; however, it is recast as a hierarchy between nations and culture, regulated and unregulated, pure and tainted, core and periphery so that the model of differentiated power and status remains. These two biomedical models are pitted against one another as competitors for medical consumers and markets.

The assumed homogeneity in biomedical models, obscures the variety in the application, practice, ideologies and access to these models in different settings. In the

transnational context I observed at the border, the beliefs of health and healing are biomedical models, but how they are put into practice and accessed are different due to different political economic situations related to aspects of health, healing and care access. For example, in the United States the models of access are based on institutional structures of capitalism where access is based on the patient's ability to pay for services. While in Mexico they are based on socialist structures of nationalized medicine where access to healthcare is a guaranteed right in the constitution, and where the government helps to regulate the cost of care and medications. Ideologically, "within the U.S. context, biomedicine incorporates certain core values, metaphors, beliefs, and attitudes that it communicates to patients, such as self-reliance, rugged individualism, independence, pragmatism, empiricism, atomism, militarism, profit-making, emotional minimalism, and a mechanistic concept of the body and its repair" (Baer et al 2003:12 – paraphrased and referenced on this page as "Stein 1990"). Within the Mexican context, biomedicine incorporates the core values of health as a human right, community, interdependence, emotional expression, and a holistic perception of the body and its restoration. These ideological contexts frame how medical practitioners view disease, illness and healing – the causes, cures, and whether your approach is curative (United States) or preventative (Mexico). Even with these differences, the Mexican medical market geared toward the U.S. border crossers modifies its approach to meet the expectations of the populations seeking care in their nation. They provide the curative measures such as medication, eye glasses, dental work and hearing aids with the preventative measures such as advice on nutrition, exercise, tooth care, etc. which

produces a new type of medical care for U.S. populations. This may account for many border crossers choosing to use the Mexican services because they feel that their doctors and providers there “care about them” more than those in the United States.

Each system offers different benefits to health consumers based on their economic resources. For example, easier access to technology is available in the United States for those who can afford it. Thus, Mexican citizens with higher financial resources cross the border to access better technology, or in some cases to access the same technology available in Mexico quicker. For instance, a Mexican citizen who, along with his siblings, helped his father (also a Mexican citizen) pay to access heart surgery in the United States explained that heart surgery is available at the same quality, with the same technology in Mexico as it in the United States; however, it is limited in quantity of availability so that a person who qualifies for access to it in Mexico has to go through a 6-9 month process (which also includes a lot of travel) to get the surgery, while someone with more economic capital can cross the border into the United States and access the same surgery in a matter of weeks. So, the quality is the same, but the time to access it is dramatically different because in this case, the technology for this procedure is more prolific in the United States than it is in Mexico. He and his siblings pooled their money together so that their father would not have to wait for the surgery by accessing it in the United States.

Another example, involves TMC communities of U.S. residents who cross into Mexico for lower cost dental, pharmaceutical and optical services. These include “snowbirds,” “day” and “weekend” crossers and year-round border residents.

“Snowbirds” are elderly populations (55 years and older) who reside in the Southwestern United States during the winter months. As an elderly population they are often subject to poverty which compromises their health and their access to health resources; thus, resulting in strategies to maximize the limited resources they have at their disposal. One such strategy is to cross the border into Mexico for care. For those who have less economic resources, Mexican border towns provide access to lower cost prescriptions, dentistry and optometry services. These groups are responding to the economic pressures of unaffordable healthcare in the United States with less expensive options in Mexico. Therefore, they are a prime example of U.S. citizens who migrate seasonally within the U.S. and who consistently cross into Mexico for healthcare (see chapter 3).

Conclusion

Research has documented that people regularly move across the U.S.-Mexican Border to access health resources and services in both nations, as effectively and affordably as possible. The reasons for this practice include the complex interrelationships between cost, income, class, insurance and risk perceptions. These factors influence the patterns of resort employed by patients, doctor recommendations and insurance coverage options. Likewise, medical values are multifaceted and are different for patients, doctors, insurers and pharmaceutical companies. They include the value of being healthy, helping others, contributing to science and knowledge, profit value and cost containment. Medical power in medical systems in both countries is tied to politics, profit and risk perceptions. My data illuminates the implications of profit, class, globalization and the effects of “for profit” medicine in a market economy. Using

a critical medical anthropology perspective, along with theories of dependency, articulation, globalization and transnationalism, my dissertation considers the implications of selling healthcare for a profit, along with medical values, power and risk at the U.S.-Mexican Border.

Chapter 3: Transnational Medical Consumers

Quotes about healthcare:

“I wish they’d fix things in the United States” (Barbara³, a married 71 year old retired bookkeeper and snowbird who lives in Washington in the summer and California in the winter, 2004).

“I think the government and insurance companies are ripping the American people off straight out!”

(Earl, a divorced 65 year old retired veteran and year-round Arizona resident, 2004).

“America is the best country in the world. It’s sad something’s wrong with the medical care system. Four more years of Bush then it will get better. We’re supporting the Mexican economy by buying prescriptions here”

(Sheila, a married 78 year old retired housewife and year-round California resident, 2004).

Introduction

The recent debates on healthcare reform in the United States have highlighted the fact that the medical system in the United States is absent or inadequate for segments of the population. These problems are not new, and with the current economic recession these populations are growing as more people are laid off, lose their medical coverage, and suffer from lower incomes due to ‘economic adjustments’ enacted by employers. At-risk populations, such as the poor and elderly, who are underserved or excluded by this care structure may appear trapped by their lack of access in the U.S. medical system. And yet, the U.S. ideology of independence and the need for treatment creates a motivation for people to find their own innovative solutions to their pressing medical needs rather than relying on the system to take care of them. This, combined with a

³ All names throughout the dissertation are pseudonyms.

knowledge of the border opportunities available, results in some people circumventing the lack of access in the United States by using another country's system to meet their medical needs (Darcé 2007, 2009; Bastida et al. 2008; Sweeny 2008; Llana 2007; Vitucci 2002; Berestein 2002; Landeck 2002; Corchado and Carbajal 2002; Associated Press 2001; Macias and Morales 2001; Fairbanks 1997; Garcia 1993; Belkin 1988). In this context, the U.S.-Mexican border provides unique challenges and opportunities for healthcare. The lower cost of procedures and medications in Mexico make it an attractive alternative for low-income populations in the United States. Thus, portions of the U.S. population practice a transnational medical pluralism, as they attempt to optimize their health by making the best use of the healthcare resources available in both countries. Economically, this practice has benefits for the populations who access health resources at an affordable rate, as well as the medical markets of the countries providing the care. Thus, there is an articulation between these two facets of cross-border practices that surpasses the border boundary.

A significant facet of the border is the fluid and continual movement of local populations that form the mechanisms for building and maintaining extensive social networks. Border populations constantly shift members, locales, and employment to adapt to their social positions as immigrants, poor, rural, or elderly populations. Thus, people have created communities that occur in “deterritorialized” space (Lewellen 2002:151) that is in both places at once (Portes 2000:254). Theories of transnationalism provide a framework for documenting and analyzing the mobility strategies and networks of border populations in their healthcare seeking strategies (Lewellen 2002; Kearney

1995; Portes 2000). To understand the connections between social networks and cross-border healthcare processes I conducted interviews and participant observation to collect information on how people began using cross-border healthcare alternatives, how and what information is shared on transborder care, and how this is reflected in actual practice, along with community creation for transnational medical consumers (TMCs). My research findings with TMCs show that social networks play an important role in shaping transnational healthcare practices through the transferring of crucial information such as which pharmacies, dentists and eye doctors to visit, where to find the best prices on medications, and how and where to cross the border. In addition, many were introduced to cross-border healthcare by friends and/or family who already practiced this form of access. These networks also use the internet to spread information as well as to research prices and facilities in Mexico.

The connections between health, medicine and class structures linked with the political economy of U.S. capitalism and class, along with the articulation of Mexico and the United States, are reproduced at the border. Articulation theory and globalization studies provide analytical tools for comprehending the relationships between the United States and Mexico expressed in national and bi-national border health contexts (Kearney 1995, 1996, 2004; Wolf 1997, 2001; Gunder Frank 1966, 1996; Gray 1986; Velazquez Flores 1996). Notably, health can be viewed within the context of these theories as a potential cost to be shifted between the United States and Mexico as each nation attempts to create and control health for various populations (Kearney 1995, 1996, 2004).

Moreover, the political economy of health offers an analysis of the macro-level structures and causes related to health, healthcare and intervention programs. The connections between capitalist configurations, including class relations, and medicine as an institution for profit rather than exclusively for health and well-being are investigated. In the United States, morbidity and mortality differentials are directly linked to the increasing disparities of wealth and income between the upper and lower classes. Thus, class is a socially created stratification and economically structured relationship that places certain groups of people "in harm's way" (Singer 2001:81, 86) by excluding them from, or limiting their access to, health resources. Analyzing aspects of health strategies and risks in this region from a political economy of health framework helps to elucidate how they are embedded in global contexts of inequality (Doyal 1979; Navarro 1976; Baer 1996; Singer 1996, 2001; Farmer 1999, 2003; Scheper-Hughes 1992).

These circumstances provide the context of healthcare access, or the lack thereof, for U.S. transnational medical consumers. This transnational group consists of a group of U.S. and Canadian seniors called "snowbirds," year-round border residents and day and weekend crossers. One of the most notable at-risk groups that are represented in all of the TMCs in the United States is seniors. Though they make up only 12% of the inhabitants, they use one third of the prescription medications in the United States (PBS Frontline 2003). Insurance coverage may be assumed to help seniors buy their prescriptions; however, most seniors rely on Medicare as their primary insurance provider. Unfortunately, those covered by Medicare during my research period in July-August 2002 and April 2004 to May 2005 did not have any prescription drug coverage

unless they purchased supplemental insurance. Those on Medicaid had some drug coverage, but the cap on prescription coverage meant that many would run out of coverage before the end of the year, so that they would have to pay all of their medication costs for part of the year (this occurred for some who purchased the supplemental insurance coverage as well). The most common health problems experienced by the transnational populations that I interviewed were heart disease, high blood pressure, arthritis, diabetes and high cholesterol. Many of the women and some of the men were also on bone density medication to strengthen their bones. Other health issues that were not as common included thyroid problems, eye sight diseases such as glaucoma, lupus, cancer, asthma, and multiple sclerosis (MS). These types of chronic health issues often require daily regimens of medication to decrease their symptoms, improve their quality of life, and/or keep the patients alive (that they cannot live without or without which will severely compromise their quality and perhaps quantity of life). These medications become life saving necessities for the snowbirds and others; thus, their restricted access to treatment due to inadequate or no health insurance, and/or high share of cost motivates them to find other avenues of access, such as cross-border facilities, in order to improve or maintain their health in the only way they can afford. This is significant for seniors in particular since, as noted above, they use one-third of the pharmaceutical medications in the United States.

As we will see below the price of these medications often make them cost prohibitive for seniors which impedes their access to “health-conferring resources” (Singer) negatively impacting their quality, and possibly their quantity, of life. These

circumstances may indicate that seniors would experience restricted availability of medications based on their lack of ability to pay; however, there is a segment of the senior population called snowbirds who have an effective strategy to mitigate these limitations.



Image 1: Transnational medical consumers waiting in line to cross back into the United States.

TMCs Defined

Typically, a snowbird is defined as a person 55 years or older from the northern United States or Canada who spends the winter months in the warm U.S. south. Generally, they live in the southwest for 5-6 months of the year, arriving sometime in October or November and leaving in late March or early April. In my research area of southern California and Arizona, a popular destination for snowbirds, people come from many different U.S. states including Kansas, Washington, Missouri, Nebraska, Idaho, Illinois, Michigan, Oregon, Montana, Utah, and New York. Several live in Arizona and California year around and a few live in Ontario, Canada the rest of the year. While wintering in U.S. southern states, many snowbirds are also stocking up on their medications, obtaining glasses and receiving dental care in Mexico at less expensive rates than in the United States.

Year round border residents are another at-risk U.S. population since many of the border cities experience high rates of poverty and thus, higher rates of morbidity and mortality (Fairbanks 1997:73-74). Nevertheless, they also benefit from their close proximity to Mexico and less costly care options available there. They have the advantage of not having to travel as far as the snowbirds do in order to access services in Mexico, as well as being able to obtain care during the entire year rather than just for part of the year like the snowbirds. Additionally, border insurance policies that cover care received in Mexico (discussed below) provide incentives to access the less costly care across the border which may contribute to a higher level of treatment than may be attained than if they were restricted to U.S. facilities only.

Day and weekend crossers are individuals who are members of various at-risk populations such as the poor, the uninsured and the underinsured. They migrate down for a day or weekend to obtain services in Mexico as well. Several live year round in the northern areas of the border states, while others live in northern U.S. states. Some of the day and weekend crossers take tour buses that originate in California or Arizona, while others carpool with family members and/or friends from as far away as Minnesota, Oregon and Washington. A few will stay with family or friends for the weekend, while some will stay in hotels or RV parks. They are also sometimes younger than the 55 years that is often the marker of a snowbird's age.

Demographics/Research Findings

Table 3.1 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 3.1: Interviewee Demographic Data

| Characteristic | Count |
|-------------------------------------|-------|
| <i>Sex</i> | |
| Female | 21 |
| Male | 12 |
| <i>Age (in decades)</i> | |
| Under 30 | 0 |
| 30s | 2 |
| 40s | 2 |
| 50s | 4 |
| 60s | 11 |
| 70s | 10 |
| 80s | 3 |
| 90s and older | 1 |
| <i>Marital status</i> | |
| Single, never married | 5 |
| Married | 23 |
| Divorced | 3 |
| Widowed | 2 |
| <i>Education completed</i> | |
| 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 |
| <i>Annual income (U.S. dollars)</i> | |
| 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 |
| <i>Insurance coverage</i> | |
| Yes | 31 |
| No | 2 |

Social Networks and Cross-Border Medical Access

Social networking is very important to the snowbirds. As the winter season begins the roads are much more cluttered as the motor homes trailing cars hooked on their tow hitches fill the highways and the local streets. I was in the grocery store one day during the winter season and two elderly couples (maybe in their 60s or 70s) ran into each other. The man, “Joe” of the one couple asked the man, “Sam” of the other, “When did you arrive?” Sam answered, “We just got in to the campground today.” So Joe said, “Well, great! We’ll have to get together for a barbeque tonight.” Sam answered, “Alright, we’ll see you back at the site.” This whole exchange was happy and excited. Even though people may not see each other for months, once they do run into each other again they pick up their friendships and connections where they left off. This population is very mobile, but still connected to one another through these flexible locales. This makes the snowbirds a transnational community that occurs in ‘deterritorialized space’ (Llewellyn 2002:151). Harry, a snowbird, provides a glimpse into how this community is connected, created and maintained through RV parks in the following statement:

About 2 years ago in a Quartzite Newspaper report there were 2 million RVs in winter from Yuma to Quartzite. There are about 800 RVs in my park and in some there are up to 2,000. The larger parks offer hobby activities, organized activities, pools, games, etc. Everybody is your friend; everybody is doing the same thing. [The RV community] is a growing community.

A BLM [Bureau of Land Management] trailer park in the desert is like a little city. It has a donated trailer that they use as a “library” where people can donate their old books for others to read, they schedule events, have a nightly roll call to check on people who were not feeling well, they have a church with a minister and he has a land based telephone, they have RV storage, and they publish a weekly newsletter of events.

There is also Courtside Park which is up the 95 north of the 10 freeway/interstate. They have tents and flea markets in February. The number of RVs rises in January-February which is the height of the busy season in this area. They will bring you propane and water so you don't have to get it yourself, but you pay a price for this, and they have stores with food.

Harry and his wife are leaving in a few days to slowly work their way back north to their cabin in Montana. Their friends from Washington State are there as I am talking with them. Their friends are going back home now in April, they came out in October. As his friends are leaving they make plans to reconnect later in the year. They tell Harry and his wife to come up and see them during the next few months because they are going to have cherries (they explained to me that they don't pick them, they "peddle" them and they made \$3,000 last year). Harry and his wife say they will go up to see them. This shows how these social connections are maintained throughout the year in other locales.

Moreover, many snowbirds move to the southwest permanently as they get older, selling their home in the north. As a result, more permanent housing is being built in the southwest to accommodate this growing population. The year round residents in the south "watch" the homes of the seasonal migrants to make sure they are not vandalized or burglarized while they are gone as part of the community connections that are developed among the snowbirds. They take care of each other and appear to have a shared sense of responsibility toward one another.

As seen above, the snowbirds form a transnational community of mobile seniors made up of vast social networks. Transborder healthcare is an important phenomena occurring at the center of these social networks. Most snowbirds began their journey into cross-border healthcare with the guidance of friends and family who were already

accessing their care in Mexico. They continue to perpetuate certain processes by passing on their knowledge of where to buy prescriptions, which dentists to see, which eye doctors to visit, which ones to avoid, etc. They also provide a place to visit for day and weekend crossing friends and family who do not make the annual migration with them to the southwest. Thus, they provide an articulation point between different populations and the healthcare system in the United States and Mexico. This is particularly important since 65% of my sample have been going to Mexico for at least some of their healthcare needs for less than 10 years, while 27% have been going for more than 10 years.

Lu, a 69 year old snowbird migrant who lives in Yuma, Arizona during the winter and Kansas the rest of the year, is a very experienced transborder healthcare seeker. Additionally, when company comes she explains that they want to go to Mexico for tourist type of activities such as shopping and eating at restaurants, not just for medications. She reveals that some pharmacies, like “the Guadalajara Pharmacy, [offer] coupons for free margaritas or papas if you buy your medicine at their store,” so you can buy your medications and then have lunch and drinks at a local restaurant. The last time she accessed services she spent 4 straight days getting major dental work done. Lu purchased two bridges and a crown for herself and a root canal for her husband. She describes the typical process of purchasing medication in *Los Algodones*, Mexico; a small border town geared toward the U.S. transnational medical service market and dubbed the “Mecca of Medicine” by a local U.S. newspaper (Coates, Healy and Morrison, 2002):

You can stay at the R.V. Park on the U.S. side of border run by an Indian tribe – I think it is called Happy Hollow, or pay \$3.00 at the parking lot across from *Algodones* [also run by the local tribe] and walk across [the border]. You write down the medication and take

that with you into Mexico and they [the pharmacy clerks] are very proficient with their medical books and will find your medications for you. Thousands cross the border every day into *Algodones*, Mexico. It is very easy to cross into Mexico, but crossing customs back into the U.S. takes about 45 minutes to an hour coming back [in the winter]. Only a 90 day supply of medications is allowed. If someone needs more, then you just go back the next day and get more. It is the same with liquor and cigarettes.

These social networks influence and shape the transnational border practices that are occurring. The way these social networks operate in helping people begin their journey into cross-border healthcare access, can be seen in an electronic discussion among snowbird migrants on an RV website in which one member asked about accessing prescription medication in Mexico. The following is the transcript of the discussion which occurred between Jan. 29, 2004 and March 1, 2004 and though they are talking mostly about the Texas/Mexico border in particular, these issues are applicable all across the U.S.-Mexican Border region. It begins with a woman from Illinois inquiring about buying medications in Mexico:

[Illinois]: We are planning on visiting Mexico when we are in Texas and my mom heard her Celebrex for arthritis is real cheap there. She is spending a fortune on it here. Does anyone know if this is true and would we be able to buy them and where is the best place to go? Thanks a lot for the help.

A member from Texas responds, "Cross at Del Rio, TX. Go to [names a Mexican pharmacy]. He is very helpful. He told me he went to college at Texas A & M."

Illinois asks, "Do you need a prescription? Are they really cheaper?"

The same Texas man replies, "Take a prescription with you to be on the safe side. But probably won't need one. If they have what you need, will be a lot cheaper. They don't have everything. Have you checked in Canada? [puts website and name of on-line store in Canada here]. Same brands as here. About 30% cheaper. Hope this helps."

A member from Bagley states, “you need no script at all, and as a convenience some Mexican *Pharmiceas* (as they are called south of the border) have a Dr. in the same building or nearby who will gladly write you a script for anything that you need for a very small fee, but be forewarned, you shouldn’t try to take anything considered a narcotic across the border back into the US, unless your mother’s Dr. in the states gave her a script proving she needs pain killers.”

A Canadian member from Toronto adds,
“I’ll have to make a small correction to your post about drug prices in Canada. Today, January 31st the exchange rate is ... One US dollar gets you \$1.30 Canadian, so the US dollar goes 30 percent farther in Canada. Then consider that ALL prescription drug retail prices here are Government controlled, at prices that are from 40 to 80 percent LOWER than US prices, for the same name brand, same dosage amount. Combining the dollar exchange rate, and the retail price controls, buying in Canada is the way to go, AND you can get the supplies delivered to your door, by mail or courier, overnight service. At least five US states are buying their meds from Canada, as are a number of cities. These are for either their state employees, or for their social service assistance programs. The folks in Massachusetts are projecting that their state will save over 90 million dollars this year alone, by buying in Canada. Of course, if you really WANT to pay higher prices, continue to buy at your local drug stores. The big US drug companies will be so happy.”

Illinois answers, “Wow! I didn’t know that about the Canadian drugs, that sounds as though that has become a big deal. Maybe it will wake someone up in the US.”

An Alabama member states, “Did not need a prescription for Celebrex last year. Don’t remember the exact cost as we were buying for so many other folks that I lost track of all costs.”

A member from Washington adds, “I believe Celebrex in Mexico (*Algodones*) was less than a dollar a pill. I don’t know what it is here in the USA but you probably can expect to get it in Mexico for around 60% cheaper. I personally don’t use it but know others that do.”

The Toronto member responds,
“I see that you live in Illinois. Do some research...I think your state is one of those that is buying from Canada, for their state employees, and retired state employees, and those on state assistance programs. As all of those things are funded by YOUR state taxes, you should be interested in

any savings that can be achieved, right? Remember that your FDA has been trying to scare Americans with hooey about the safety of drugs made in Canada...A large load of crap, as many of those drugs are made in Canada, all right, BUT are made in plants OWNED by American companies, located in Canada. I think that this scare tactic is directly tied to the cozy relationship between the FDA and the big US drug companies, who are afraid that they are going to lose their stranglehold on the US drug buying public. Having the FDA do the dirty work for them, to scare American consumers away from making a free choice, about where to buy, and how much to pay.”

A member from Tucson, AZ cautions, “My son in law is a pharmaceutical rep. He says drug quality is not always the same. You might take a bottle with you to check the contents.”

Montreal Canada states, “For your info. Celebrex is available from Canada at a cheaper price. [Adds a link to “check these prices”].”

A member from New Mexico adds, “My wife and I have used Mexican *Pharmacias* for the last 15+ years with great results. The University of NM@ Las Cruces did a study a few years back and found that the 15 most prescribed drugs were just as pure and in some cases more so than US drugs. By comparison- Nexium (prilosec) 40 mg cost here is \$145.00 per 30, cost in Mexico – is \$32.00 per 100 – All made from the same company. Exchange rate in Mexico is usually around 9.5 to 1. All Meds are quoted in USD. Drugs in Mexico are regulated by the Government also.”

A US and Canadian member shares, “We are wintering in Yuma and we just got back from *Algodones*. We have also bought these drugs from Canada and here are the comparisons:

| | US | Canada | Mexico |
|---------------------|-------|--------|--------|
| Vioxx 100 25mg | \$357 | \$149 | \$48 |
| Premerin 100 .625mg | \$32 | \$19 | \$8 |
| Lopressor 100 50mg | \$17 | \$14 | \$8 |

There are about thirty pharmacies in *Algodones* and they are all about the same price, you do not need a prescription.”

A second member from Washington warns, “We bought my wife’s prescriptions like (the US and Canadian member) and my wife is lucky to

be alive. We buy from Canada now and [they are] the same as we buy in the USA. We know a large amount of RV'rs buy in Mexico with good results so we might just be the one that wasn't lucky."

A member from Alberta Canada finished off the discussion by saying, "From what I saw last year, a lot of drugs in Mexico were the same stuff (Brand Name) as in the US and Canada. I think you'd be safe buying the Brand Names. Off brand stuff, on the other hand, would worry me a little..." (RV.Net 2004)

This discussion shows how information is shared through this broad community (which is now also located in the deterritorialized space of the internet/world wide web). These networks of shared experience are very important. For example, the novice TMC is being guided in the "do's" and "don'ts" of cross-border care in Mexico. She is told whether she needs a prescription; that she should buy name brand drugs rather than generic; that the medications are cheaper in Mexico (and Canada); and that she should not try to take narcotic medications back into the United States without a U.S. doctor's prescription. Cautions of the possible risks are also shared by those who have had negative experiences with their drug purchases; however, it is interesting to note that one of the people who had problems acknowledges that he and his wife may have just been "unlucky ones" since most of the "RV'rs" that they know "buy in Mexico with good results." This statement indicates that it may be a safe practice, but that they may have just made a bad purchase, based on the numbers of those who have success with it. The other caution comes from the mother-in-law of a pharmaceutical representative, which can affect the credibility of this account. Interestingly, the members attempt to counter the risk campaigns presented by the FDA and pharmaceutical companies that suggest that the drugs bought outside of the United States are unsafe, by using their experiences and

information on the drug companies owning and operating the manufacturing plants in Canada, which suggests that they would be safe or at least the same as those available in the United States at much higher prices. They also advise the use of name brand drugs instead of generic as a safety measure. The information provided in the discussion also includes a comparison and details about access in Canada as another option for those in need of less costly medications. Each person draws on the information, experiences and “facts” that they have learned from their participation in cross-border care and as a member of the transnational medical consumer community to support their viewpoints on the practice. Overall, it is a positive, encouraging, how-to guide for a newcomer where information is shared freely and openly to minimize her risk and help her have a successful experience. This type of indoctrination into the practice of transnational healthcare access is quite common. In fact, TMCs in my sample share many of the same experiences and perceptions of buying medications in Mexico, including the warnings and cautions.

When asked how they started accessing services in Mexico, over 90% of the TMCs that I interviewed said that they learned about it from friends, family members, neighbors and other travelers who were already going to Mexico for those reasons. For example, Carrie was on a Christian bus from Prescott, Arizona on a community tourist trip to Colorado and found out about coming to *Los Algodones*, “A lot of them get their dental, glasses and medications here in *Algodones*.” Bill stated that, “We moved here for the scenery. Everyone else comes here to *Algodones*. We came here first to shop.” Tourist items like blankets, jewelry, clothing and knick-knacks in the various shops and

stalls surrounding the healthcare offices and pharmacies also draw U.S. customers. Karl learned about this practice by walking over the border and talking to people who were doing this every day. Lu explained, “We started about 28 years ago. We’ve been going at least that long. The neighbors – she had arthritis too – were going there and that was how we found out about buying medications in Mexico.” Dana and her husband found out about Mexican medical services during their first trip to Acapulco in 1979. They met family and friends from Kansas there who were buying prescriptions in Mexico and that was how they found out about it. Then they visited their friend in Yuma and found out about *Los Algodones* where they went regularly until they acquired more comprehensive insurance coverage in the United States. Barbara stated, “People we talked to in the past came down, and had no problems. So we thought we would try it last year and [they have the] same bottles, sealed, (70 mg) just like at home – exactly.” Harry heard about people 30-40 years ago going to Mexico for services and medications. His daughter-in-law and her grandparents lived down in Arizona and they bought their medications, etcetera in *Los Algodones*, Mexico. John explained that a friend of theirs works as a manager in a dental clinic and she told their other friend (also from Seattle) to come across the border for dental work – she came and inspected the office and said it was okay. So, their friend recommended them. Margie was told about going to Mexico for services by people in their area and her husband’s brother lived in Yuma one winter and he came to *Los Algodones* and then told them about it. Nancy’s aunt and uncle live in Yuma and go to *Los Algodones* for their care and prescriptions. They told her to come down for a visit and see for herself. She asked them, “Is it worth the money in gas to

come down here?” Apparently it was, since now she comes down twice a year and buys 6 months of her medicine at a time. This trip she carpoled with several others and they split the gas which further reduced the cost for all of them to come down. She is thinking about also getting her dental work done in Mexico. She is trying to save enough money to be able to get some work done next winter. Tony’s family comes to Mexico 2-3 times a year. Tony and his wife came with them the last time and checked it out for themselves. It was much cheaper so they came back. Others have been told by their doctors to go to Mexico to buy their medications since they cost so much less. Wilma’s doctor in Oregon told her that if she came to Mexico to get her medications it would pay for her trip. On Rick’s first dental trip he and his wife went to a dentist recommended to them by someone they knew who went there. It was one-fourth or one-fifth the price charged in the United States.

Relationships with Providers: I am a person, not a number

Eighty-seven percent of those interviewed stated that they went to the same practitioners every time they went to Mexico for care. When explored further, this meant that they went to the same eye clinician and dentists, but not necessarily the same pharmacies. The snowbirds, year-round border residents and day and weekend crossers have built relationships of trust with the practitioners so they will only go to certain care providers. They maintain the same types of connections with their Mexican dentists, eye care providers and sometimes the pharmacists that have with each other. I often watched as patients caught up with the personal happenings of their providers and vice versa, while making plans to have lunch, dinner, or even attend social functions like a

daughter's engagement party together. Generally, however, they see the pharmacies as competing to give them the lowest prices, so they shop around to get the best value on medications. As seen above, recommendations from other TMCs, friends and family play an important part in the decisions that people are making. 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 American people there, I never see a Mexican there." This is interesting because it indicates that strong connections among community members is not necessary for one to recommend a provider in Mexico and that there is an implicit trust among community members that they would give you good advice. Chrissy said she was recommended by a friend for her glasses. "When I got my glasses, my friend from California told me the one she went to was \$185.00 for 2 pairs (one regular and one sunglass) and only \$10.00 for the eye exam. It was the exact same prescription. I paid \$40.00 instead of \$300 for glasses for 1 pair of bifocals." For her dentist she stated, "I just went to different ones – I shopped around." Carrie explained,

I go to the same dentist. There are 4 people who work in his office. He has a packed office, others don't. I interviewed others who went to him. I researched him for a year before I started with him. I started with another and she fixed a tooth and it broke and I couldn't find a second one to get it fixed [until the recommendation from her friend]. I rotate from pharmacy to pharmacy for the best price.

They also develop relationships with their providers as evidenced by Carrie's dentist allowing her to make payments; they didn't at first, but once they got to know her and she showed that she was "responsible" they let her make payments instead of making her pay in full at the time of service. She began going to Mexico in January 2003, 2 years before our interview. "I saw an ad in the newspaper [and] I made friends with the people on the

bus from Palm Desert.” She can pick up the bus at a couple of locations in the Palm Springs area, so this has become her preferred method of transportation to Mexico when she needs to access medical resources. Bill and his wife know their dentist – they met him personally at a party given by their friend. His brother is an eye doctor in the same town. They feel comfortable with him because they know him personally and so does their friend.

Rick’s wife “was recommended by someone who had been there” for the dentist, but for the pharmacy they just walked in the door. Harry explained, “Yes I go to the same doctor and clinic, but I go to different pharmacies due to differences in what they have available. Some of the main ones have stopped carrying certain generics due to pressure from prescription drug companies in the U.S.” He used to buy a generic medication from Belgium, but this year the pharmacies on the main street say they don’t have it, but if he goes to a back street pharmacy he can find it there (he joked that he goes to the “drug pushers” on the back alley). The generic costs him 20% less. He is confident with the medication he buys because many of the people who live in the RV park with him take them and “I haven’t found anyone dead yet lying around the RV park” due to “bad stuff” or medication from Mexico. Margie said, “Yes, I go to the same place for the dentist and glasses, but for the pharmacy, no. We go to 3-4 different ones.” Nancy explained that she went to the same pharmacy rather than shop around, “because of competitive prices they all charge the same so I just keep going to the same one.” Dana explained that “No [I don’t go to the same pharmacies,] because you shop around – hunt for the best bargain, haggle for the cheapest price possible and there are 50 million

farmacias down there so it makes it easy to shop around for the best price - plenty of choice [and competition].” In addition, some pharmacies would be out of the medication that she needed or wanted so she would have to go other places for that reason. Lu stated that, “Yes, I have special friends that I go to, but I shop around at 5 or 6 pharmacies to get the cheapest price. This year they asked what the price was at the other pharmacies and offered to match the competitor’s prices; this was first time that they did that.” Even though she likes to shop around at the pharmacies, there is one she prefers over the others, she explained, “I prefer to go to the one I go to because it is run by a doctor. He does two things at once” he is a doctor diagnosing and prescribing and then dispensing what he prescribed.

It is important to note that recommendations are not the only way that people choose a provider. For instance, Ryan was in *Nogales* when he had an abscess and needed some dental work done. He saw a sign, the dentist spoke good English, and so he went in for a consultation. His work was going to cost \$250 in Phoenix, but only cost \$45 in *Nogales* so he went ahead and had the work done in Mexico.

Insurance Coverage: Exclusion and Access

Medical insurance coverage is an important factor in healthcare access whether in the United States or Mexico. Of those I interviewed, all but two people had some type of insurance. A few had Medicaid, however most had Medicare and a supplemental insurance to help cover what Medicare didn’t. Some of the coverage came from employee retirement benefits, some were military veterans and received insurance from a veteran plan, others had HMO or PPO plans such as Blue Cross and Aetna and the

Canadians had their Canadian insurance, plus a supplemental U.S. plan to cover them during their travels in the United States. The lowest income groups were eligible for Medicaid. The few interviewees who had this coverage did have some prescription provisions during my research period, but they would reach their maximum and run out of medication coverage within 6 – 9 months and then have to pay the full price for their medications for 3-6 months of the year. This is particularly difficult for elderly populations since they experience higher rates of chronic conditions such as those listed above, that require daily medication that is often very expensive. An example of how extensive medication use can be for an elderly person is seen with Roger, a 71 year old man who took the following 14 medications concurrently to maintain his health: Altace 5mg, Isosorbide 30 mg, Lipitor 20 mg, Levoxyl 75 mcg, Nadolol 40 mg, Hydrochlorothiazide 25 mg, Enteric coated aspirin 81 mg, Potassium Chloride 10 meq, Voltaren 75 mg, Atarax 10 mg, Clobetasol .05, Protopic .1, Combivent (2 puffs 4 times daily), and Nitro Quik .4 mg. The high costs of these medications, along with how many they may have to take simultaneously, make them difficult to obtain for many seniors who live on limited and/or low incomes and have inadequate insurance coverage. These circumstances essentially place their lives at risk due to their economic position and their inability to obtain “health-conferring resources.” For instance, Carleen takes Lipitor to keep her cholesterol down, Fosamax for building bone density, along with Prevacid and Zolofl for a total monthly prescription bill of nearly \$600. She explains that “It was getting so it was more than my Social Security, so I was debating whether or not to eliminate some of them” (PBS Frontline 2003). Many seniors find themselves in the

economic predicament of having to decide how best to afford their medications. Some cut their pills in half and only take half the amount they are supposed to, while others may take their medications every other day instead of every day to help save money and stretch their medication dollars. Others, like Carleen, try to figure out which medication they can do without so that they can afford other necessities such as food and rent. For the snowbirds and other transnational populations, their use of transborder healthcare allows them to independently solve their healthcare dilemmas by circumventing the lack of access in the United States and gaining access in the more accessible Mexican care system. In order to continue with their life saving medication regimens they cross the border to access the non-Medicare covered procedures and medications with providers in Mexico where they are available at a much lower cost than if they attempted to access these in the United States. Many snowbirds were also accessing dental work and eye glasses along with their prescription medications in Mexico since those services are not covered by Medicare.

The fact that most of the snowbirds accessing care in Mexico have some type of insurance, points to their underinsured status and the inadequacy of the insurance programs existing in the United States. Insurance coverage is directly linked to the services that snowbirds and others access in Mexico. The Mexican medical market responds to the needs of the consumers crossing the border for services and supplies. For example, hearing aids have become available through Mexican providers. This is intriguing, because many insurance policies only cover the diagnostic procedures and not the actual hearing aids which typically cost between \$1,000 and \$3,000 (or more) for one.

This follows the pattern of Mexico offering the services and items that U.S. citizens are not able to access through insurance or the healthcare system in the United States. When asked what their plans covered many transborder healthcare practitioners explained what was lacking instead. For instance, Grace stated that her prescription coverage was “shit! I have it, but it doesn’t cover anything” and she has two insurance plans that provide some prescription coverage. Others had vision plans that would only cover their eye exam and prescriptions, but not their glasses. Carrie explained that she had dental insurance, but cancelled it because it was “no help at all. It cost \$23.00 per month and didn’t pay for anything.”

Insurance coverage influences cross-border care in other ways as well. For instance, Dana a 72 year old snowbird and California resident explains how insurance affects her and her husband and their access to health resources such as prescriptions,

[My husband and I] used to go [to the same small Mexican border town] every year [before they retired]. We went from Secure Horizons to Aetna seven years ago when we got on Medicare [when they retired at age 65]. We were supposed to have a \$5.00 co-pay for prescriptions with Aetna, but that was not the case, so we went to court to sue them for false advertisement. It was a big production, but we won. So now as long as we are with Aetna we are supposed to receive the lowest co-pay available – which is still \$5.00 for now. So now with the Medicare and Aetna prescription coverage we have, we haven’t gone [to Mexico] for four or so years.

Their insurance coverage thus, coincides with their shift in care access from Mexico to the United States. Dana and her husband began purchasing prescription medication in Mexico in 1979, before they had insurance coverage. However, once they had U.S. insurance coverage they could afford, they stopped going to Mexico for their medications. Their insurance coverage, or lack thereof, still influences their Mexican

healthcare access. Her husband currently needs 2 dental implants and they do not have dental coverage so she turned to Mexico for affordable access as she did in the past with medications. Dana went to a website listed on a flyer her friends in Yuma gave her for dental care in Mexico. She faxed the Mexican dentist office the information on what needed to get done (from Loma Linda (located in Southern California) where the original work and diagnosis were completed) and sent them an email asking for prices that she compared with Loma Linda. It was much cheaper in Mexico, and as a result Dana's husband is planning on returning to Mexico for the implants. Her friends in Phoenix and Yuma have gone to Mexico for dental care and say that the places there are spotlessly clean and they have been very happy with their results; thus, she is comfortable with her husband going there for his dental work.

There are some who do not go to Mexico for healthcare or medications. When asked why not most responded that they were able to gain access in the U.S. or Canada so they didn't need to go to Mexico for these reasons. Most have insurance coverage that provides them with adequate access. For instance, Phyllis explained, "We [she and her husband], have insurance coverage. If we didn't have it, then we certainly would [go to Mexico]. They have good dental care here [in Mexico]. We have been investigating it for our friends who are on a tight budget, a limited budget." This is the same situation we see above for Dana and her husband where her insurance coverage influences her decisions to buy medication and services in the United States or Mexico. Another TMC, Cathy explained, "I don't need anything." She and her husband have employee sponsored healthcare insurance that provides medical, dental, vision and prescription

coverage. Some haven't needed to yet, but say they would if they needed to; for instance, Jake stated, "I bring [my high blood pressure medication] with me from Canada. I can bring a 180 day supply." His wife is on Lipitor and she gets it in Canada as well. "[But], if I had a toothache I would come here to *Algodones* because the guys I golf with do. [But] I haven't wanted or needed [to yet]." He said he would also buy his medications here if he needed to, but he would get a referral from a friend "so that I'm not flying blind." Since he and his wife are Canadian citizens, they have Universal Health Care coverage from Canada, plus they buy U.S. coverage in Canada for \$1600 for 6 months for him and \$610 for his wife (she is only 59 years old so her coverage is cheaper). His U.S. insurance covers getting him stabilized in the U.S. and then flown home to Canada for further care. John states, "I get all of mine done over there [in the United States], I don't get much done" because he has insurance coverage for his needs, but it doesn't cover dental work, which is why his wife does get dental work done in Mexico.

These experiences reflect the interesting paradox of insurance coverage and access to healthcare. Many believe that if you have insurance coverage, then your access to care is sufficient to meet your needs; however, as seen above, this is not always the case. Interestingly, all of this insurance coverage will not cover what the transnational consumers buy in Mexico, so they pay out of pocket for everything there (unless they are year-round residents and have a border policy – discussed below). Even so, it is more affordable for them to make these purchases than to buy more insurance, or to pay the deductibles and co-pays with their insurance plans. Surprisingly, when asked if insurance coverage influenced their choice to use services in Mexico approximately half of those

interviewed said yes and half said no, even though the services they were accessing corresponded with those not covered, or not covered well, by their insurance programs. Those who stated “yes,” explained that it was cost effective for them to do so. For instance, Barbara explains, “Yes, because [we] don’t have any insurance coverage for these services. If we have to pay for it, it’s better to pay less. We would rather buy it at home, but we can’t afford it there. We would probably buy from Canada, but we think that Bush is going to shut down Canada.” They didn’t make a special trip to Mexico for their medications but were buying them since they were in the area. Ryan said that his insurance coverage did affect his choice to go to Mexico since “It is considerably cheaper in Mexico. It pays to make the trip from Phoenix to come down here [Mexico].” Isaac who is on Medicaid also explained that, “I have to pay for my medications myself for three months [of the year].” Most echoed the cost savings for the out of pocket costs for prescriptions and dental work. Carrie provided another reason why people are coming to Mexico, “I have to wait 3 months to see a dentist in the United States. Here in *Algodones*, I call and see them next week.” So, care services in Mexico are more readily available at more affordable rates than in the United States and this draws the snowbirds and others to cross the border for care (at least in this area of the border).

In addition to the snowbirds, the day and weekend crossers who came to Mexico for care on a one – day or weekend turn around trips are also affected by insurance coverage. The most common attribute of this group of people is again the lack of healthcare insurance for accessing services in the United States. Some did not have any insurance, while others had deductibles that were so high, that the cost of paying for the

medications in Mexico was actually less than their deductible would be in the United States. In fact the cost savings were such that it made economic sense to go to Mexico even when the travel costs were calculated into the cost of the medications.

Border policies (shift of value – world systems)

Another way that the insurance market has been influenced by Mexican health options are the border policies that are offered to those working and living in the border area (this is defined in miles from the border, and each insurance company has its own way of defining this space). Many employers along the border, such as farms and the Calexico City Hall offer these border policies to their employees to save money for both the employer and the employee. They work by offering the insured care in Mexico with no or lower co-pays than a comparable U.S. only plan. So the employee must go to Mexico to see the doctor, go to the dentist and get their eye glasses, but they can receive emergency care in the United States if necessary. The typical co-pays are reduced from the average U.S. co-pay of \$15.00 per visit to either a \$4.00 co-pay or for some policies, no co-pay. This alone can produce significant savings for the patient seeking care. Additionally, their prescription costs are lower, since again the co-pay is lower or non-existent depending on the plan. The outlay for the employer is much lower as well which means that some employers who could not have offered health insurance to their workforce due to the cost can now offer this plan to their employees and provide them with healthcare (Darcé 2007; Berestein 2002; Mena 2002; Associated Press 2001). Thus, the less expensive healthcare options available in Mexico provide a healthcare supplement to the more expensive (and therefore, exclusive) U.S. healthcare system.

Jean, a Calexico City employee, explained that city workers get coverage for care in its sister city, *Mexicali*, Mexico, and are reimbursed for any care they receive in other Mexican cities like *Tijuana* or *Algodones*. The *Mexicali* hospital and doctors are part of the Calexico City Hall's provider group. For many of her care needs, such as glasses, she prefers to go to *Los Algodones*, but their providers are not part of the group so she has to pay up front and then get reimbursed by the city for her costs.

Table 3.2: Cost Comparison of Medications in the United States and Mexico

| Medication | Cost (U.S. dollars) | |
|--|-----------------------------|--------------------------|
| | 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 |
| Sintroid | \$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 |

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

Table 3.3: Cost Comparison of Medications in the United States, Mexico, and Canada

| Medication | Cost | | |
|-----------------------------------|----------|-------------------|--------------------------------|
| | 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

Why cross the border for care?

One of the first questions that people have about transborder care at the U.S.-Mexico Border is: “Why are people crossing into Mexico for healthcare?” The most common answer by far is that “It is cheaper there” (Tables 3.2 and 3.3). As seen above, cost is critically tied to insurance coverage and the access of medications. The price of prescriptions is so high that without insurance coverage many cannot obtain this necessary health resource. Phyllis elucidates, “Seniors, don’t have medical coverage, they 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 the scooters, for services.” Betty explained,

Because I can afford it here [in Mexico] because it is cheaper. We buy the ones that are lower than our deductible in the United States. It’s ridiculous [the prices], especially the medications. If they [the pharmaceutical companies] didn’t do the advertizing they do for the medications you need a prescription for anyway [then people could afford it]. Three page ads in magazines and TV always say ask your doctor if this can help you.

Barbara states, “Because Fosomax was so expensive back home [in the United States]. We could get a year’s supply here for one month’s cost at home and it has gone up since then” from when they checked prices the year before. Jessica stated, “Price. It is less than 1/3 of United States prices. My insurance doesn’t cover prescriptions. We got enough for 1 year or more.” Nancy, whose income is social security disability, expounds, “Because I am on disability and I can’t afford the co-pays.” Ryan also finds the savings to be what draws him to Mexico, even though he is Canadian. He is on a limited income

and the savings is 80% compared to the United States and 60% compared to Canada.

Chrissy agrees,

I come to get medications cheaper. I can buy 3 inhalers here for the price of 1 in the U.S. It's a big savings. [And others come] because they can't afford to buy [medications] in the U.S. I saw a poor man who was sick and was told it was \$100.00 for his pills and he said, 'I'm sorry, I can't afford them.' I felt so sorry for him. I'm limited too because I'm working, but my husband can't work.

Karl explains further,

Price. Price is the whole thing. Our American medical system is a greedy rip off. Drug companies, doctors, American Medical Association (AMA) and hospitals have control. It is just greed. Phony logic of research [costs] by drug companies – not true, it would be done anyway. Profits go through the roof, like oil companies. We are spending the winter here. We came for cheap medications. We can't afford it in the U.S. It is \$800.00/month for my wife's medications [in the US], and we don't have insurance, so we can't afford it.

They go to Mexico when they are in the southwest and Canada when they are up north.

Lu agrees,

Cost – it is much cheaper in Mexico, about a third or fourth of what it costs in the U.S. My husband paid between \$.16 – .24 per pill for his high blood pressure medication in Mexico and between \$.96 – \$1.54 per pill in the U.S. If it was cheaper I would buy in the U.S. and at my age I don't know how much longer I will be able to travel to Arizona. But for now we are lucky and can go to *Algodones* for our medicines.

Maggie exclaimed, "Cost! Absolutely, I would say 100% cost." Her friend buys 6 months

of medication and saves \$1,000 for 1 medication. Nancy adds,

Primarily the prices. We are on fixed incomes and everything else goes up. There was a 17% increase in medications with only a 2.9% increase for cost of living for Medicare. Electricity, cable, food, gas all increased, but the money is not increasing and there are only so many corners you can cut. What you can cut, you do.

She said it was better to buy her medications in Mexico than taking only half of her medications or taking her blood pressure medication on alternating days to make it last which she has done in the past. She also relies on free samples of her medications from the doctor when he can give them to her. She stated that it is cheaper in Mexico than in Canada – “much cheaper here.” Wendy added, “Prices. In the United States they’re stripping people of the money they have. [For example,] Prilosec generic, 100 count is \$14.00 in Mexico, and 30 count for \$135 for generic in the United States.” She has asthma and the doctor in Oregon told her if she came to Mexico to get her medications it would pay for her trip. Rick adds, “A lot of people here are from out-of-state, for example from Minnesota, here for the winter, and fill their prescriptions while they are here. People are trying to save a buck.” Julie describes another way that buying medications in Mexico can save a person money, “you don’t have to go to the doctor for prescriptions” so you save on the doctor visit co-pay, as well as possible loss of wages for the time it takes to visit the doctor.

As seen above, the savings can be considerable, especially for those taking more than one medication. 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 \$15.00 for one month of generic pills in the United States. In Mexico she gets 3 months of generic medication for \$6.00. So she saves \$39.00 for 3 months of medication, which adds up to a savings of \$156.00 for the year, for that medication. She also buys Prednisone, Prozac, and Actinal for her osteoporosis. The Actinal costs \$53.00 for four tablets (one month dosage, one pill per week) in Mexico and \$90.00 in the

United States before she reaches her co-pay deductible of \$500.00, then it goes down to \$45.00. So, if she buys her Actinal in the United States with her insurance deductible, she would pay \$810 for one year, at \$53.00 per month in Mexico, she would pay \$636 per year, which would save her \$174.00 per year, for that medication. Since she can buy all of her medication in one to two trips, the savings on that one medication alone would cover her expenses to travel to Mexico for her medications. If we add her savings for just two of her medications, thyroid and Actinal, she has saved \$330.00 for one year's worth of medication. She buys an additional 10 medications which will increase her savings, making it very cost effective for her to travel the distance to Mexico. Moreover, she carools with her friends, so this further reduces her travel costs making the savings even greater. She reports that all of her medications from Mexico are fine. Another snowbird, Barbara, explains, "My medication is \$17.00 per pill in United States, and \$4.50 per pill in Mexico. In the United States a 3 month's supply is \$210.00, in *Algodones* it was \$187 for 12 month's supply last year and about \$100 for 3 months this year – this is the same at all of the pharmacies in *Algodones*." So even with the price increase it is still cheaper in Mexico than in the United States for her medication. Another snowbird buys his arthritis medication in Mexico for \$2.23 for 20 pills, making a 90 day supply cost about \$10.04, or less than one month's co-pay for most insurance programs. Several others stated that they saved at least 50% over U.S. medication prices. An additional snowbird stated that her medications were 40% cheaper in Mexico so she paid about \$480.00 in Mexico per month of medication rather than roughly \$800.00 per month for the U.S. price. Carrie explained that one of her prescriptions is \$10.00 in Mexico compared to

\$40.00 in the United States, and that price is with insurance coverage. Ann pays \$5.00 in United States for one inhaler which is her insurance co-pay (her insurance is provided through her employer) and \$5.00 for 3 inhalers in Mexico.

It is not just medications that they are saving money on. Tony states, “[Care] is less expensive [in Mexico], most of the time.” He explains that eye glasses are one quarter of the price in the U.S. His wife’s glasses cost \$300 with insurance in the United States, and only \$88.00 in Mexico, including the eye exam. He knows co-workers who come down here to Mexico for everything. They also know a couple of women who also come here for dental work, eye glasses, and medications. These women also go to a doctor in Mexico who is from the United States but practices in Mexico. His in-laws also buy all of their medications here and have not experienced any side effects.

Earl, discussing dental work, adds, “Much cheaper and good work – better work here [in Mexico] than in the States. [There are] no problems with their work here, [but there are] many problems in the States.” He wouldn’t have the work done that he has had in Mexico done in the States. “I have state insurance coverage for dental care, but the deductible is so high – that’s why I come here [Mexico]. I have been coming here for 1 month now for my dental work.” He had crowns, bridge work, a root canal and a pulled tooth in Mexico for \$800.00. This would have cost him \$3,000-\$5,000 in the United States according to his figures. John clarifies that it is all about “Money! We are getting ripped off in the States because they wanted \$15,000 in the United States and only \$2100 in *Algodones* for 2 root canals, 1 replaced cap, and a couple more teeth capped for my wife.” Katie went down twice and plans to go back in a month for another crown. She

had a cavity filled, crowns, 2 root canals, bondings, cleaning, etc. for \$900. She was very happy with them and said she “will never go to a dentist in the U.S. again. The dentists are nice, friendly and get you in there as quickly as possible.” While she was in the waiting room she was impressed by a woman who drove straight from Minnesota just to see this dentist.



Image 2: A transnational consumer getting dental work done in Mexico

Another group that is accessing medications in Mexico is Canadians who are traveling through the southwestern United States. I was surprised to find Canadians in Mexico purchasing medications since Canada has a socialized medical system and has more economical medication prices than in the United States (this also draws U.S. seniors to their country to access medications). However, Mexican pricing can be significantly less expensive than Canada, which is why some Canadians are stocking up on their medications in Mexico alongside the U.S. citizens there (Table 3.2). The Canadians that I interviewed were in their early 60s and explained that once they reached the age of 65, they would be able to get all of their necessary medications for an annual co-pay cap of \$200.00. Thus, at that age they would not need to buy their medications in Mexico anymore since it would not save them any money at that point. Another Canadian snowbird who is 65 years old did not buy medication on the day I spoke with him, but he did check to see if he could get his medication Biaxin in Mexico and found that he could. It costs \$32.00 for 10 days worth, but it is free in Canada with the federal drug plan because he is 65 years old. In Canada he has a \$4.50 co-pay until he pays \$200 and then all of his medications are covered for free.

Better care: “They care about you here”

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 some 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 feeling that the U.S. system doesn't care about them is reflected in their beliefs that the care is better in Mexico than in the United States. For example, I was told about a doctor who gave an 800 number to his patient and told her to call him if she had any problems at all and he would talk to her personally and take care of her. The couple telling me this story was very impressed by this as they felt it showed a concern on the doctor's part for his patients. It also touches on the patient/doctor relationship desired by the patients – feeling like the doctor is there caring for you and knows you. Many also feel that the care is better due to better knowledge or access to better treatments than those available in the United States. For instance, Julie heard that the doctors in Mexico are “far advanced in arthritis treatment and they are. The drugs are safer for arthritis,

rheumatoid arthritis especially.” Bill explains further, “We have found that they have very clean offices and [they have] some machines that we don’t have in the U.S.”

According to Harry, “Price is the number one factor, and then availability.” He told a story of a co-worker who worked with him at a refuge and had been sick for a long time with something that the U.S. doctors kept misdiagnosing and treating to no avail. So he took him to a doctor in Mexico that his daughter-in-law goes to, so he trusts him, since the co-worker suspected that he had a tropical disease that the U.S. doctors were not familiar with and that was why they could not diagnose and treat it correctly. The idea was that the Mexican doctors are more familiar with these types of diseases and thus have more success in diagnosing and treating them. In this case, the Mexican doctor “got it right” gave him the correct medication and his co-worker got better right away. Harry explained that people “Also, [go] for cancer treatments in Mexico – there may be some shysters in that, but some treatments approved and used in Europe are good, but they aren’t available in the U.S., and in some cases it seems that Mexican doctors are more advanced in this area because they have access to the European treatments.” John concurs, “[The] doctors are good – accredited and all that jazz - and they don’t gouge you.”

The benefits that the TMCs perceive are available with the practice of cross-border healthcare revolve around price, accessibility and courtesy/friendliness of the providers. Bill explained that the benefits of going to Mexico were cost savings and trust,

Price again, it comes right to money. All senior citizens are on social security and have to go to where they can get the most care for the least amount [of money]. I also trust who is doing the work. I have had a bad experience in the U.S. with a dentist who charged me \$1200.00 for a

procedure that would cost \$200.00 here in *Algodones*. Also, you can get a free consultation with a dentist in *Algodones*, but in the U.S. they will charge you \$90.00-\$100.00 for a consultation and that is above the price of the procedure! They take care of you [here in Mexico], but in the high season [November – April] you have to sit longer [and wait] but it is the same in the U.S. Only in the U.S. it will take 2 months or more to get in to see the doctor or dentist but in Mexico, they will get you in sooner than that.

Carrie added,

The drugs cost anywhere from half to 10% of the U.S. prices. Once I had to drive due to having consecutive days of dental appointments, but usually I take the bus. It saves on gas with the high prices now. It is \$25.00 round trip for the bus trip. I get lunch here cheap. I arrived here more relaxed because there was no strain of driving myself. For the most part I found them to be just as clean as we are. Everybody is very courteous and concerned [about you]. You're not just a number like you are in the States. Some doctors in the U.S. have been wonderful, but they are very expensive. It seems like there is no personal care [in the United States]. I had to wait for 3 weeks for an appointment and then they told me to go to the hospital.

Grace stated that the benefit for her was that her dentist “is courteous, good about helping and she spoke good English.” Karl put in “It’s cheap and they get you in and out the door.”

Access to Medical Resources

Interestingly, most of those interviewed did not report having any access problems in the United States, even though the fact that they were accessing care in Mexico would contradict this. They did not perceive a problem with access as far as gaining entry; they saw it as a problem of affording what was easily accessed in the United States with money or insurance coverage. This may also be a reflection of medical hegemony and the combined effects in the pursuit of health, and the ideology of independent responsibility for healthcare that is seen in the United States, where

healthcare is provided by the system and it is up to the individual to secure access to it through insurance coverage or direct payment. Most snowbirds had doctors in the United States because their insurance coverage would cover their doctor visits. They went to Mexico for all of their needs that were not covered, or cost less than their deductible or share of cost in Mexico. They were looking to reduce their out of pocket expenses and increase their health.

Importantly, four did state that they had access problems in the United States. Isaac explained that he had “A bit [of an access problem] because of the whole rigamoral I would have to go through.” He would have to make an appointment and have to get a referral for a specialist, and then make an appointment with the specialist, nothing was streamlined. Chrissy explained that, “I should have [gotten services in the US]; but I don’t, just because they’re too expensive.” Carrie reveals another issue with access through her experiences with the hospital that is just 10 minutes from her house. One time, she was bitten by a dog and an hour later she was still waiting for care, they “forgot I was there.” Two times she was there with pneumonia and sat there for 6 hours before they saw her. She concluded, “People in that Valley have problems accessing reasonable healthcare – there is not a doctor who I would trust.” Karl and Dana state that there are no problems “as long as we can pay for it” and that “without insurance it is too expensive.” Ryan, who is from Canada had another view to add when asked if he had any access problems in the United States, he answered, “Yes and No. When I first started coming down I had a bad bronchial attack and had Canadian insurance coverage in the U.S. and I could not get into a doctor’s office in the U.S.” He called the insurance

company and they tried to get him into a doctor's office as well and they could not either. He ended up going to the emergency room and he stated that they were not happy to see him either since it was a trauma hospital and they did not feel that he needed treatment at their type of facility. Dana explained that she went to U.S. providers all year round to access "routine" healthcare such as doctor visits and prescription medications because she and her husband can afford it with Medicare and Aetna insurance coverage but that without insurance it is too expensive. Again we see that when allowed to define access themselves, they do not refer to medications, glasses or dental work, the exact items that they obtain in Mexico due to their difficulty in acquiring them in the United States. Perhaps their perception of these as not healthcare is a reflection of the implication that the U.S. system does not recognize them as healthcare through their lack of coverage for them.

Notably, respondents did not report having any difficulty accessing services in Mexico either. For instance, Rick states, "Just call and make an appointment. Not a big deal. [Its] a lot busier here than in California." Grace explained that she was given a business card with her dentist's email address from the woman who recommended her to this dentist. When she arrived at the border a year later, she emailed the dentist to set up her appointment.

I don't get healthcare in Mexico!

Remarkably with all of the access of medications, glasses and dental work, most of those I interviewed stated that they did not access healthcare in Mexico. I purposefully did not define the term 'healthcare' when I asked the TMCs if they accessed healthcare in

Mexico so that they could define it in anyway they wanted. This way I could try to understand their perception of healthcare and access patterns. What was interesting to me was that 88 percent said that they did not see the medical access that were obtaining in Mexico as healthcare and thus answered “no” to the question. Yet, when asked about specific access such as medication, eye glasses and dental work they said yes and a few of respondents gave the answer “not yet” indicating that they would access these types of services in the future. This suggests that there is a difference of perception or definition of healthcare and the services they were accessing for the TMCs. They were buying medication, eye glasses and dental care which they did not perceive as ‘healthcare;’ instead, they defined healthcare as seeing a doctor and/or hospital procedures such as lab tests or surgeries as healthcare. Yet they also saw these services and supplies as essential to maintaining their good health and their quality of life. Notably these are the aspects of healthcare that are covered by their Medicare and Medical or other insurance coverage which legitimizes their categorization as healthcare while the procedures and items that are not covered may be delegitimized in that category. This could be an indicator of how institutions shape popular viewpoints of healthcare systems, responsibility, necessities and access for these and other populations.



Image 3: A sign welcomes snowbirds to a business in *Los Algodones*, Mexico



Image 4: A main street in *Los Algodones*, Mexico.



Image 5: A second main street in *Los Algodones*, Mexico.

Economic Growth Industry for Mexico

Economically transborder healthcare is a win-win situation for the U.S. TMCs and the medical providers in Mexico. The U.S. populations obtain their necessary medical procedures and medications not covered by Medical and/or only partially covered by Medicaid or other insurance programs while the medical industry in Mexico thrives. This cross-border medical access has resulted in many Mexican border towns experiencing tremendous growth in these services. For example, *Los Algodones*, a small Mexican border town dubbed “the Mecca of medicine” by local U.S. newspapers, had approximately fifty dental offices, twenty-six pharmacies, twenty optician offices and fourteen doctors’ offices in a six block radius from the border crossing in 2002 (Coates, Healy and Morrison, 2002). When I conducted my fieldwork in that same small town just a few years later it had approximately 86 dentist offices, 24 pharmacies, 29 optical offices, and 6 doctor offices (4 general and 2 hearing aid offices), along with several barber/beauty shops, a health food store, restaurants, bars, souvenir shops and stalls, a bakery, and liquor stores (some are pharmacies too). Furthermore, this town was continuing to grow, as I conducted my count in 2005, more offices were being built in two story buildings and along maze ways of corridors with shops and stalls surrounding them. Additionally, this town has mitigated the potential language barrier by employing bilingual people who speak English. Every office and pharmacy has at least one person (many have more) who speaks English, so the English speaking U.S. and Canadian customers don’t have to worry about not being understood, or understanding their healthcare provider, making it an even more popular place for them to go. In fact, this

town is so popular for cross-border healthcare, it has been featured in various California newspaper articles (Vitucci 2002; Medd 2002), on the PBS show “California Connected” and is the featured destination of a ‘day tour’ from Palm Springs, California and Prescott, Arizona, where people take a bus to this little town in Mexico to spend the day picking up medications, visiting the dentist or eye doctor, shop, have “lunch and a beer” and then return to the bus to be driven back to Palm Springs or Prescott. Many even choose this town over larger cities, for example, Lu explained that she and her husband used to go to *Mexicali*, a large urban center on the border, every year, for a friend of theirs from Nebraska with asthma to get treatment, “They have great doctors, but I don’t like the town. It is very dirty, not friendly, not safe, but that is my opinion. I like *Algodones* much better. It is clean and friendly, like a little neighborhood.” Cleanliness was very important and they often comment that a good provider has a “clean office” or “clean shop” as evidence of how good s/he is.



Image 6: Help wanted sign in dentist office window requesting a fluent English speaker in *Los Algodones, Mexico*.



Image 7: "Hawkers" for the Purple Pharmacy in *Los Algodones*, Mexico.

Since there are so many offices in the maze way of corridors it is easy to miss some of them. This is where the job of the “hawkers” is most important. As soon as you step across the border there are several people, usually men, with flyers, cards and other advertisements to hand you as they ask you what you need for the day. “Do you need a dentist? A pharmacy? Eye glasses? Cigarettes? Tequila? Tell me what you need and I’ll take you to a good place for it.” They can help a person navigate the many plazas and corridors on their way to an office and the hawkers get paid for every customer they bring in which makes them highly motivated to get you to that office. They can be very helpful, but they can also be a bit bothersome and most who cross frequently into this small town know where they are going, so they begin to tell the hawkers the same responses to try to get them to leave them alone. The Purple Pharmacy made up t-shirts poking fun at some of the snowbird responses and had their employees wear them. They had an old bird pulling an oxygen tank on the back with the 10 most popular sayings of the snowbirds, including statements like “I already have a dentist” or “I don’t need that today.” I found that answering them in Spanish actually stopped them in their tracks. They were often surprised that I spoke any Spanish and began talking with me about that instead. Even though they can be a bit bothersome at times, they are an important aspect of the transnational medical access occurring in *Algodones* as they ensure that consumers get to providers and that providers can stay in business with all of the competition and crowded store fronts. This also provides another avenue of employment for Mexican residents who are bilingual which contributes to the economic value of this cross-border strategy for *Los Algodones*.

Conclusion

The data gathered underscores the disparities of insurance and healthcare access of various populations in the United States that results in the practice of transborder healthcare. 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 acting on the ideology of independence and pressing health needs have found their own solution to their healthcare obstacles by crossing into Mexico and obtaining their medications and services at an affordable rate. These populations are challenging the ethnocentric notions that health and care in the United States are better than everywhere else, through their experiences and the experiences of those they know. Thus, their empirical data of their own experiences debunk the myths perpetuated by the corporations, government and media; who they don't trust, as they believe these groups are motivated by profit and greed, rather than wanting to improve their health (Chapter 5). Their networking adds an element of safety by removing the mystery and the unknown from the equation – they can trust 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. This transnational medical pluralism occurs where the people's agency, needs, and willingness to traverse a national border to access care combines with the economic incentives of Mexico to provide the needed services for those populations. This practice economically benefits the U.S. populations by saving them money and providing access to otherwise unaffordable care. It also benefits the Mexican providers economically by providing them with a market for these goods and services. As long as

the U.S. healthcare system neglects certain sectors of its population, this practice will continue as it has for decades.

Chapter 4: Three TMC Case Studies

Introduction

The case studies presented in this chapter provide a detailed view of how cross-border healthcare operates for transnational medical consumers (TMCs). The process of gathering information on how to access care, where to go, and what to do is demonstrated along with insight into the way that social networks operate for TMCs. They illustrate the relationships between the Mexican practitioners and U.S. patients, and within the TMC community. In these examples, I am at the center of the network, as it was through my research and experience during my participant observation and interviews with TMCs at the U.S.-Mexican Border, that the other two people came to access care in *Los Algodones*. Since they knew me and were my friends, they trusted the information that I had about providers, services and medications; thus, they were willing to explore transnational care as an option to their unmet care needs. Additionally, I provided a local place for them to stay and acted as a guide to the town which made the care in Mexico more accessible.

Three areas of access are revealed through these stories. The first story is about how I was able to obtain hearing aids for the first time due to their lower cost in Mexico. The second story illustrates how one of my friends acquired vital dental care and eye glasses that he was unable to afford in the United States. The final case study is the story of my best friend who purchased eye glasses and a prescription for contacts while her father, a snowbird, was able to buy essential medication to make up the gap in coverage in his Medicare supplemental insurance.

In the following cases I provide detailed dialogue as it occurred between the TMCs and the various providers which illustrates several important aspects of cross-border care including the manner in which relationships are developed and maintained in these interactions. They become more than exchanges between a patient and provider, they become markers of friendship and caring that make the patients feel protected, safe and nurtured. They feel that the Mexican system sees them as a person rather than as an insurance number, mainly due to the way they are treated by the providers. They are recognized when they arrive and the initial exchange is about their families, current events in their lives and their health status. The setting that emerges from these dialogues is one that suggests the patients are important as a whole person, not just for whatever ailment they are there to deal with. These conversations also occur in English, which contributes to U.S. consumers feeling at ease within the Mexican system. Therefore, the discussions that occur before, during and after the provision of services are critical to building trusting relationships between the providers and consumers and to the facilitation of cross-border access for those new to the practice. It becomes clear that these relationships, along with more affordable care and medications, continue to draw TMCs to Mexico in order to circumvent their lack of care in the United States.

Participant Observation

Growing up, I always had medical and dental care through my father's work insurance policy. Once I began going to college, I was insured through my university's health plan for students. Most of my health, dental and vision needs were met with these policies. In 1999 I was diagnosed with a bi-lateral hearing loss (this means in both ears)

in the speech range. I can hear sounds above and below the speech range, but tones/sounds in the speech range drop out for me, so that I can hear that someone spoke, but I cannot comprehend what they said, unless I am looking at them. This hearing loss requires hearing aids to help me; however, my university health insurance did not cover the hearing aids. This apparently was not uncommon as, according to my doctor, the majority of insurance policies did not cover them. My insurance, like most, covered the doctor visit to diagnose my hearing loss, covered the visits to adjust them, and make sure they worked for me, but would not help pay for the actual devices. The better private and work policies, I found out later, would help pay for them, but only up to \$1,000. This may sound like a decent amount; however, the two that I would require would cost \$3,000 (\$1500 each) or more. I blanched at that since there was no way in the world at that time, on my limited fellowship that barely covered my rent and living expenses, that I could afford \$100 toward hearing aids much less a few thousand. The doctor, trying to be helpful, suggested that I could just buy one for now –I couldn't afford one by itself any more than I could afford the two, so this really wasn't a solution at all. So I waited for several years, and then as I was conducting my research in *Los Algodnes*, I discovered that they sold hearing aids. I decided to explore this option to see if it would work for me.

Mexican Healthcare

My experience with Mexican healthcare began with my dissertation research. As I explored the experiences of other U.S. citizens and residents who crossed the border regularly to access medications, dental care and eye glasses, I began my own practices of

access. My first visit to *Los Algodones* was with a Calexico City employee who has a border policy through work that provides her and her family with affordable care in Mexico. She is Hispanic and speaks Spanish fluently and is very comfortable going to Mexico for care. Her provider group is located in *Mexicali*, Mexico which is the sister city to Calexico. She goes to the dentist and orthodontist in *Mexicali* because it is so close, just a short walk through the border gate, making it easy to go to these frequently visited providers. However, Jean prefers to drive an hour away to *Los Algodones* for her family's eye glasses because of its small town feel. She buys eye glasses for her and her son at the office called "Eye Care." The last time she went, she was able to get glasses for both of them for \$100.00 because of a special they had.

Based on my research interests, Jean offered to take me to *Los Algodones* in August. She suggests that we go on a weekday since many businesses close on the weekends due to the intense summer heat that often reaches 116-120 degrees during the day. "In the summer here, people hibernate inside, like the Eskimos do in the winter," she chuckled. This heat results in fewer customers during the summer off-season than during the winter season when the temperatures are much more tolerable and the snowbirds arrive. During "the season," as it is referred to, thousands more people cross into *Los Algodones* so the offices and shops are open on Saturdays and some even on Sundays in order to capture as much business as possible.

My First Visit

We are lucky today; it is only 105 degrees so it is cooler than it has been lately. After meeting at Calexico City Hall, Jean and I took highway 98 from Calexico to

highway 8 near Arizona because she liked that drive better than just taking the 8 directly from Calexico. It was a longer, more round – a – bout route, that winds along the All American Canal. The farmland gradually gives way to caramel colored sand dunes that are a popular destination in the winter months to ride motorcycles and quads while camping out in an RV. These dunes are also rumored to be the same that George Lucas used when filming his original Star Wars films. Border patrol cars parked under permanent shade structures observe our travels as they watch for people illegally crossing into the United States. The bottles of water and Gatorade left on the side of the road are the other visible indication that anyone may be crossing this deadly desert landscape. The inspection station we drive through is another symptom of the attempt to prevent illegal activity along the border. It is unmanned on our side as we travel toward the border crossing to go into Mexico, but it is open and stopping cars on the opposite side which means we will be passing through it on our way back. The sign announcing “Mexico next exit” guides us to the off-ramp that will take us to *Los Algodones*. As we exited the freeway and entered the Quechan Indian Reservation that borders Mexico several advertisement signs for doctors, dentists and pharmacies in *Los Algodones* dot the desert landscape assuring you that you are in fact on the correct road. The Sleepy Hollow RV Park on the right side of the road is the first sign of businesses in the area. It is a small, sparse place surrounded by a row of trees that provides easy access to *Algodones* and not much else. It is run by the Indian tribe and is located right before their parking lot that is open daily from 6 a.m. to 10 p.m. Arizona time, the same hours as the border crossing. We paid our \$3.00 parking fee to the attendant in exchange for the yellow

ticket/pass, parked the car and then walked down the ramp, through the gate and across the border into Mexico.

Our first stop was the tourist office to pick up maps. The little adobe style building is located in front of the building that houses the public bathrooms. Though *Los Algodones* is relatively small, 3 main streets running east and west (A, B, C), in a grid like pattern with 3 main streets that run north and south (1,2,3), it is jammed packed with store fronts, stalls, and restaurants arranged in mazelike corridors surrounding plazas, some with fountains. Since it was summer, there were only a few ‘hawkers’ out trying to drum up business for those providers that would be impossible to find without help. I took the papers they offered with information and discounts to various pharmacies, dental offices, eye care providers and restaurants, but otherwise, ignored them so that they would not persist in pushing us toward one provider or another. Since this was my first visit, I was there to drink it all in, get my bearings, see what there was to see and to begin pricing services and medications to understand why people came to this small, dusty town for healthcare. Jean led me up and down the various streets showing me offices and providers, patiently waiting as I took pictures and began to get a feel for this “Mecca of Medicine” (Coates, Healy and Morrison, 2002). She even treated me to a refreshing raspado (shaved ice drink) off a local street cart to offer us some relief from the burning summer sun.



Image 8: Hearing aid office in *Los Algodones*, Mexico.



Image 9: Hearing aid receptionist Maria and my family in front of the fountain in the courtyard behind the office.



Image 10: Hearing aid receptionist, Maria, in the waiting area.

Hearing Aid Bargains

As I wandered from dentist offices, to pharmacies and optical offices documenting prices and services, I rounded a corner and instantly my fieldwork took on a more personal note. In front of me was a bright cheery, yellow office with a green sign stating “hearing aids.” My previous experience with cost, hearing needs and curiosity compelled me to find out if the *Los Algodones* provider would finally make the previously inaccessible hearing aids available to me. Since, as my data collection thus far demonstrated, medications, dental work and eye glasses were much cheaper in Mexico than in the United States, I was sure that the hearing aids would be too. I was not disappointed. But, growing up with the adage, that “you get what you pay for,” I also wanted to see if the doctor would diagnose me the same way I had been diagnosed a few years earlier by a U.S. doctor at a top medical school facility in the United States (a measure of quality control) and what the quality and manufacturing of them would be. It turns out that this office and the option of buying hearing aids in *Los Algodones* was new, only becoming available the year prior (though they were available earlier in other towns and cities).

I entered the Optimus hearing aid office through the glass framed, French style door. Though there was a fan running, it was not much cooler inside than it was outside. The friendly English speaking receptionist, Maria greeted me smiling.

I explained, “I would like to get some general information on hearing aids.”

“Are they for you?”

“Yes.”

“We have 20 years of experience” she assured me. “The hearing test is \$20.00, but it is free if you buy the hearing aids from us.”

“How much do the hearing aids cost?”

Maria showed me a brochure with a variety of hearing aid styles while explaining the price structures. “The regular hearing aids [analog] are \$450.00 - \$850.00 each. We also have digital hearing aids that are \$850.00 - \$1500.00 each. That is 50% off of US prices and they have a 2 year warranty.” She informs me that they are made in the United States. The office sends the prescription and ear mold to the manufacturers in Florida and then they send the finished devices back to the office via UPS in one week, unless they are marked urgent, then they arrive in 4 days. “We can also mail them to you in the U.S. We deal with all of the best companies in the U.S. like Bell Tone and Omni.” She further explains that these companies give them a good deal. I wonder to myself, “How do they manage to sell them at half price to this office but not in the United States?” I decided to make an appointment for the following Tuesday for a hearing test. I made sure not to share any information about my previous hearing test results so that I would not inadvertently skew the results. I wanted to see what they would come up with on their own. I figured that this would be a ‘test’ of their abilities to accurately determine what my hearing loss was and if they ‘passed’ then I would have high confidence in their ability to prescribe the correct hearing aids for me. Especially since these would be the first ones I ever had. I was cautiously optimistic about possibly being able to get hearing aids.

The Perils of Summer Appointments

On my second visit to *Los Algodones*, I arrived on time for my 11:15 a.m. appointment with the Optimus hearing aid doctor and saw the ever friendly Maria who greeted me in English, asking how I was doing. It was a bit cooler in the office today than it was when I was there a week ago. Maria asked, “Do you have any other appointments today in *Algodones*?”

“No,” I responded.

“Is your friend with you today?”

“No, I am by myself today.”

“Do you need to leave? Because the doctor, he is going to be a little late.” He was working in his other office located in San Luis.

“That’s okay, I can wait,” I assured her as I sat down and began looking through a brochure on San Luis. Maria continued looking through a Good Housekeeping magazine with Joan Lunden and her twins on the cover. After a few minutes, we began talking about the magazine articles and ads for a while. After 45 minutes of waiting she made a phone call to the doctor explained that the doctor was still busy in his other office and would be about 45 minutes more. Apparently this can happen frequently in the summer, but only rarely in the winter season.

“Do you want to wait?” she asked.

“Okay.”

“The doctor is working with a child with severe problems so it is going to take a long time. Like maybe an hour or hour and a half.” Maria seemed anxious about me waiting,

but I was fine since I really wanted my hearing exam and this was my fieldwork, so I was willing to wait as long as necessary for the doctor to arrive. Meanwhile, she asked if I wanted something to drink. When I said yes, she led me outside through the courtyard, past the dry fountain and into a small shop with several small cooler refrigerators with Coke, Coca-Cola Light, other sodas and water. Maria bought me a bottle of water and herself a Coca-Cola Light for 10 pesos at the center island surrounded by several shelves of touristy knick knacks for sale, including tequila and cup sets with the tequila bottle in the shape of various characters.

On the way back to the office, we stopped in the dentist office next door. She went inside the exam room while I waited in the waiting room and reception area. To pass the time, I looked at the diplomas of the husband and wife team of dentists that work there. They both had a diploma from UABC (University of Baja California). She also had another dental certificate framed alongside his two certificates from the health office. On the opposite wall was a small corkboard with letters and pictures from prior patients who were thanking them for their work. One, from a Canadian couple, thanked them and said that they were handing out their cards to their friends who planning on coming down in the fall. This card and the others like it, points to the networking that brings people to *Los Algodones* for various healthcare needs. Their display of diplomas and patient letters provides an atmosphere of medical authority and knowledge along with caring and patient satisfaction.

When we went back into the reception area for the hearing aid office, Maria told me that she was talking with her brother who was getting some dental work done.

Showing me a picture out of a magazine of what she wants her teeth to look like, she shared that she wanted to get dental work done there too. As we chatted, passing the time waiting for the doctor, Maria showed me pictures of her son, daughter, and husband, along with the ear doctor and his son while sharing personal stories about each one. She told me that her daughter was finishing up school in Sonora, was currently teaching swimming classes and was going to be a sports trainer/teacher working for the Olympics. As we continued sharing personal details of our lives we slipped into Spanish, which was great practice for me. The dentist from next door and Alma, the hearing doctor's daughter, came over and joined our conversation. Everyone was friendly, smiling and chatting away. It helped the time pass quickly and helped me build lasting relationships with them, just like the other transnational medical consumers do when they come to *Los Algodones* for services. Even though the conversation revolved around seemingly insignificant small talk, it was an important step in building rapport between me as a patient and the providers. My contact with these dentists in this context, along with the documents on their walls, led me to bring my friend there for his dental work a few weeks later (see below). I may not have chosen their office without this interaction and the recommendation of Maria who I was beginning to befriend.

About 1 or 1:15 p.m. the doctor showed up. "I'm sorry for being late," he said as he shook my hand in greeting, "thank you for waiting."

I smiled, "It's okay. No problem." Our exchange was conducted exclusively in English. A common practice in *Los Algodones* to help their U.S. patients feel more comfortable and confident in the care they receive since they do not perceive a language barrier

between them and their provider. He then led me to the other office where he conducts the hearing exams and hearing aid prep. This office was much cooler. I waited in the waiting area while Maria and the doctor went inside the smaller examination room. After prepping the exam room and washing his hands, he invited me in. I sat inside the tiny, hot and stuffy sound booth that was encased in egg crate material to help make it sound proof. As he placed earphones on my ears, he smiled and said, “You are too young to need hearing aids.”

“I know,” I frowned.

“You might hear some static or scratching noises, but just ignore them. Only respond to the beeping sounds you hear. Lift your right or left hand to show which ear you hear the sound in.”

It was a standard hearing exam that I had done before. I sat in the booth with my back to the doctor who watched me through the booth’s only window as I lifted my right and left hand when I heard sounds. As a long time elapsed between sounds, I began feeling awkward knowing that this should not be the case; confirming once again that my hearing loss is real. After that test was administered, he told me to tell him when his voice was too loud and he began saying “hello” with increasing volume until I said stop. He opened the door to the booth, removed the headphones and asked, “How did you come to have this problem with your hearing?”

“I think it was caused by ear infections that I had as an adult,” I explained.

Nodding his head, he replied, “Ah,” indicating that this seemed reasonable to him.

Then he escorted me from the hot, stuffy booth to the black leather patient chair so he could use a scope to look inside my ears.

“Everything looks good,” he smiled, “you have small ears.”

“Really?” I asked with a small laugh.

He smiled, “Yes, that’s good.”

He showed me my hearing exam results. The pattern on the chart matched the results from the hearing exam I took 5 years ago in 1999. He confirmed that I needed hearing aids and that the tones I miss are high frequencies that are mainly used in speech. This made me feel secure that the doctor was as good as the one I had in the United States since they came up with the same results.

He showed me two different small hearing aids that fit inside the ear canal, one was analog and one was digital. He told me that for me, since I waited so long for him and he values my time, he would take off \$250 from the analog and \$300 off of the digital so the prices would be: analog \$1250 (normally \$1500), digital \$1600 (normally \$1900) for both. I sat there frowning and said, “I don’t have the money for the hearing aids right now and I am not sure which ones to get because I have never had hearing aids before.” He explained the digital ones may be better for my type of hearing loss and that the sounds are usually clearer with those.

“Can you pay the \$1250 for the analog ones right now?” he asked.

“Probably,” I answered.

“Okay, then you pay that when you pick them up in a week and then pay the rest in September whenever you have it. I trust you because you have an honest face.”

I frowned, “I won’t have the money for a couple of weeks.”

“Fine in two weeks,” he smiled and patted my arm reassuringly.

I put down a \$20.00 deposit, and then will pay \$1230 in two weeks when I pick up the hearing aids. Then in September I will pay the \$350 balance. The fact that I could make payments over time and that he would order the hearing aids before I finished paying for them reflects the type of trusting relationships that are built among the TMCs and the providers. This is also different from most access in the United States where you need show proof of insurance or pay up front for the full cost of your care. It contributes to the perception that the Mexican practitioners are more caring and see patients as people rather than profit (but of course, they still represent profit since this is a business as well, but the feeling is different due to the different way the interaction occurs).

After working out the payment plan, he put a small dark gray cylindrical sponge with a 2 or 3 inch piece of string hanging off of it into my ear canal to protect my ear drum from the mold compound used to make the mold of my ear for the manufacturers. The powder compound was mixed with water in a small cylinder and then squeezed it into my ear. While it set, I had to open my mouth as far as I could and move my jaw back and forth. He did the same procedure with my other ear. After about a minute he loosened up the mold and took it out of my ear by pulling on the string. Those will go to Florida with my prescription and they will make my devices. They have a 2 year U.S. warranty, so if anything goes wrong while I live in El Centro I can mail them to the doctor and he will fix them and mail them back to me. After I am not living in El Centro anymore I can write a letter and send them directly to the company in Florida to be fixed.

I can't wait! A couple more weeks and I will be able to hear better for the first time in years! This relief and excitement mirrors how many TMCs feel when they first begin to access care in Mexico. It is almost unbelievable that you can obtain the services and supplies that you are denied in the United States. Furthermore, the manner in which you are treated makes you feel like they have empathy and sympathy for you and that they will do whatever they can to help you. It is like reaching a sanctuary of relief for your pain and suffering.

Hearing aids

On my return visit the temperatures are starting to cool signaling that the winter season is soon to come. With more tolerable temperatures sure to come and Memorial Day weekend just around the corner, more people are visiting *Los Algodones*. For the first time, as I pulled up to the parking lot I saw several cars parked along the side of the street leading to the border crossing to avoid paying the \$3.00 parking fee to park in the Quechan Indian reservation parking lot. There are signs saying no parking, but no one seems to take notice or get ticketed so there isn't a consequence or deterrent to them parking there. Even though it was still mostly empty as the season hasn't started yet, there were several more cars in the parking lot and 3 buses from Prescott, Arizona that had brought 'day-crossers' in for services and medications.

I walked across the border watching the 3 Mexican border patrol agents monitor the cars passing into Mexico on the single lane street that makes up that border crossing. Since I had \$1200.00 in cash in my purse to pay off most of my hearing aid balance, I walked quickly and purposefully to the hearing aid reception office where I was greeted

by Maria. The doctor was not in yet, he had called her from the road on his way in. So, we chatted a bit about her hairstyle and the upcoming Memorial Day holiday which she was unaware of until a woman called and wanted to know if she could make an appointment on that Monday even though it was a holiday (she could, which illustrates the accessibility of the service providers in Mexico compared to the long waits reported by TMCs to see their U.S. providers).

She called the doctor after about 10 minutes to see how close he was and he was already here, so we walked over to the other office. Opening the French door, the doctor and his wife entered the office. Each in turn took my hand and greeted me asking how I was. I told them I was fine and asked how they were; they too were fine. He apologized for postponing our meeting for a week, I said it was okay. Then we went into the exam room and he took out my hearing aids, put the batteries in and explained that the blue was for the left side, red for the right. He turned them on and put them in my ears. It was strange, I could hear a lot of sound, but I could also hear myself since the hearing aids go into my ears and plug them up.

“They have a two year warranty. If you need to mail them to me, mail them to my address in the United States – it is on this card – otherwise, if you mail them to me here in *Algodones* they will be lost. Okay?” I nodded as he put the card with his U.S. address in the hearing aid storage box. He showed me the proper care for my aids. There was a booklet as well from the company that explained my hearing aids, how to use them and interesting enough only a one year warranty. Dr. Nunez also put in the extra two batteries from the pack he used to initially put the batteries in my aids.

He told me to wear them as much as possible and that at first I would probably only be able to wear them for a couple of hours. I also need to retrain my brain to ignore ‘white noise’ sounds like fans and pay attention to the voices again. This is actually how I know when I have reached my hearing limit with the aids (which occurs as predicted within 2 or 3 hours of putting them in) because the voices get ‘muted’ and I feel like I need to turn them up again. For the most part I like wearing them as the sound flows to me rather than me chasing it. He also told me to practice with the volume by listening to the radio and making adjustments.

As I left the office with Maria and walked back to the reception room, she asked me how it was and I said it was weird, but good. We passed the fountain in the small courtyard that was now running. “Can you hear it?” she asked.

“Yes, much louder than I could before,” I said. Walking past the dentist office I noticed that they were open on Saturdays from 8 a.m. – 2 p.m. I asked Maria for confirmation,

“They are open on Saturday?”

“Yes. Why?”

“I want my friend to come in and get a check up to see what work they will need to do to fix his teeth.”

“I can make the appointment for you with them” she said, handing me their card and her card again, “call me for the appointment. They are very good doctors.”

“I believe that they are since I saw their office and their diplomas on the wall.”

She gave me a strange look when I said that, and affirmed that “It is a clean, good office.”

“Yes it is.”

Then we said our goodbyes. Her comment about the office being “clean” and “good” reflect the comments made by TMCs when they recommend an office to another person from the United States. This appears to be countering the perception that unsafe offices are “unclean.”

I walked to the U.S. border office where two officers were sitting at their desks checking people as they crossed back into the United States. The one at the desk on the right asked me, “US citizen?” I said, “Yes” and nodded. He smiled nodded back and motioned with his hand for me to pass. Four elderly people passed ahead of me with bags from the pharmacies and they went through the same procedure.

When I reached the parking lot I passed a Hispanic couple who had parked and were going into *Los Algodones*. I have also seen people who look like ‘bikers’ with long, gray beards, tattoos and leather vests with a smattering of patches. There were two “Master’s touch” tour busses parked by the fence and I walked up to the two men who drove them and were cleaning the windows on the second bus. One of them turned to me as I approached and asked, “Do you need to get inside?”

“No,” I smiled. I thought that question was interesting since it indicated that it is not just elderly people taking these tour buses to *Los Algodones*, because he did not bat an eye when he saw me, and I am obviously not an elderly person. “I am not on the bus. I was curious where you are from.”

“Prescott, Arizona.”

“Oh, I heard that there were day tours out of Palm Springs.”

“There are. You should call Cardiff and Celebrity Tours. They come from Palm Springs and come out here 2 times a month, or every two weeks. I am talking to my boss about coming here more too. We only come once a month.”

“Okay, thanks, I will give them a call. Bye.”

“You’re welcome. Bye.”

I walked back to my car and headed home thinking all the while about the implications of tour buses heading to *Los Algodones* for medical and dental services and what it means to the little dusty town’s economy as well as to those excluded from the U.S. medical system. My own experience of being able to finally have hearing aids after years of not being able to afford them meant a change in my quality of life. I could not in good conscience keep that to myself. Any time I heard a person worrying about not being able to afford their medication, or dental work or eye glasses, I told them about *Los Algodones* – how to get there, how to navigate the system there, what was available, the providers that I knew and went to, how to go on line to their web site (losalgodones.com) for directions and links to various providers, and so on. In some cases, I even took them there and became their guide. Thus, in conducting my participant observation, I ended up becoming part of the social network of transnational medical consumers that helps everyone they know access the inaccessible in a small border town at the edge of Mexico.

It is clear that this little town serves a great purpose for those in need of its services. I and my friends can attest to the health and lifestyle benefits that come from our access to care across the border. The next two case studies will share the experiences

of my friends who benefited from their ability to access services in Mexico that they could not access the same way, or in some cases at all, in the United States.



Image 11: Me, my family and the dentists that worked on my friend's teeth in front of the fountain in the courtyard behind their office.

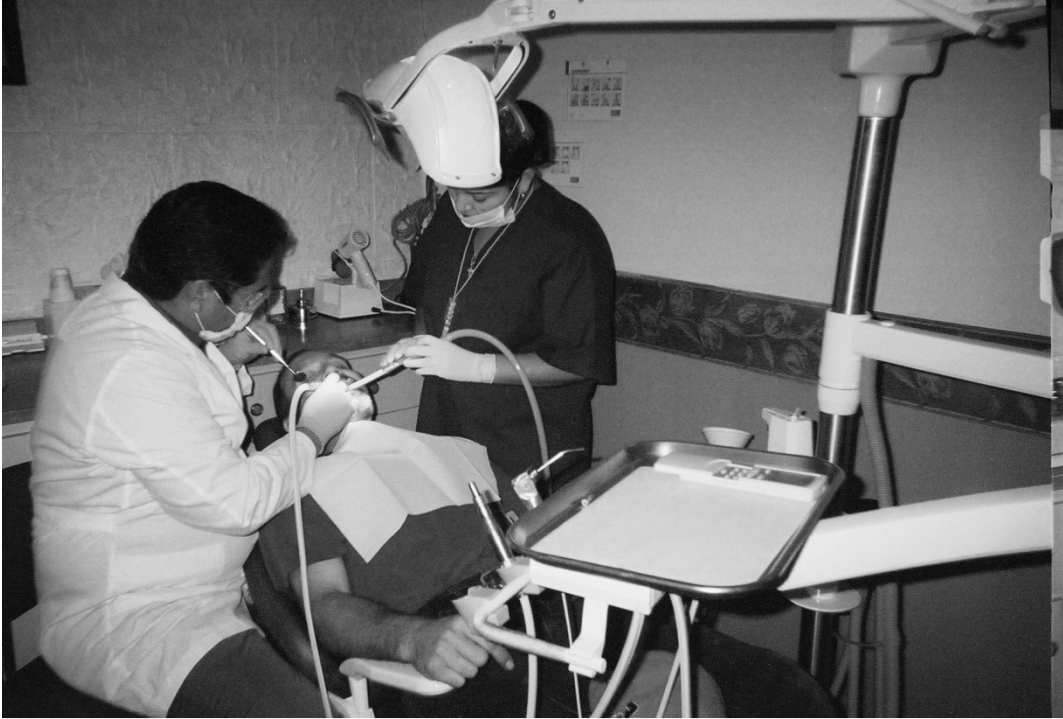


Image 12: Travis getting his teeth worked on by the dentist in *Los Algodones*, Mexico.

Travis – a weekend crosser

Travis is an unmarried father of four with a 12th grade education. At 35, he works as a handyman for his father's home improvement business. "I fix things in people's houses that are broken - doors, garbage disposals, fences, light fixtures, locks - pretty much anything. You name it; I fix it or install it." He also cleans pools as a side business to earn extra money to support his family. He does not have insurance coverage through work and is unable to afford to buy it on his own, so he puts off going to the doctor or getting any dental work done, including cleanings. At one point he needed a tooth pulled so he went to a "free clinic" that turned out to not be so free, or so good at providing services.

I needed a tooth pulled because it was hurting really bad. I went to the free clinic. I had to wait- in pain- for 3 hours just to get seen. And there were other people there in more pain than me I think, and they had to wait even longer! Then the doctor actually put his knee on my arm to get leverage to break my tooth into 3 pieces to take it out! And then they charged me \$35 at the "free clinic" to take my tooth out – so it wasn't even free!

Additionally, Travis needs eye glasses to see generally well and for driving, so he gets them at discount retailers when he can afford them.

Reflecting further on his past insurance coverage and how he came to Mexico for care, he explained,

I don't remember if I had any healthcare when I was a child, I went to the dentist once or twice that's all I remember. I never went to the doctor. My dad was a fireman so I must have had some insurance through his work, but my parents were divorced when I was two years old, so I don't really remember.

When my kids were little we all had Medi-Cal. But since I didn't want to do the GAIN program they cut me off [but the children were able to stay

on]. Since 1993 or 1994 I haven't had medical insurance. I didn't really need to go to the doctor. I would get a common cold once a year or so and I would just stay in bed until I got better and that was it. I didn't go to the doctor or the dentist [since then] and my teeth were decayed from when I did drugs years ago. I had yuck mouth. I felt sick and my teeth were hurting really bad. I had trouble eating. In the U.S. they wanted about \$10,000 to fix my mouth! I couldn't afford that. And after what happened to me at the free clinic I didn't want to go back there. So I used a lot of over the counter things, lots of 'Orajel'! I had bottles of it everywhere – one in my car, one in every room of the house. Then, my friend Jennifer was working down by the border and heard about all of these people going to Mexico to get dental work, medical, eye glasses, medicines and such. She met some dentists down there that had a good reputation and so I went to the dentist in Mexico. And when they told me the price to fix my whole mouth which was less than the price of fixing one tooth in California, I said, "Let's do it."

Word of mouth first got me to go there. I went to *Algodones* to get eye glasses first and to check out the dentists. The dentists were so much cheaper there that I decided to have them look at my teeth and see what they could do. Then once I was there and they cleaned and x-rayed my teeth and told me what was wrong, I felt like they knew what they were doing. And I looked at their credentials [diplomas] on the wall - they were from a university in Mexico, so I thought that was good. I made sure that I knew that they knew what they doing, just by the questions that I asked and that they had up to date equipment. The equipment and everything was nice and clean, almost better than a dentist office here in the United States if I think about it. The receptionist spoke English and Spanish so it was easy to talk to the doctors to tell them what was wrong with my mouth and for them to tell me what they were going to do [through the translator]. The dentists spoke broken English too, so I felt very comfortable. After talking to them a few times I decided to let them fix my mouth.

Travis' initial visit and investigation of the dentists and their office built his trust in them and their ability to do the work he needed. Since I was the one who introduced Travis to the dentists in Mexico, I went with him on all of his visits. His first visit on September 25, 2004, consisted of an examination, x-rays, a cleaning and a quote for the work he needed done. This dentist's office is run by a husband and wife team, with the wife's

sister as the receptionist and translator. The husband, Doctor Rodriguez, performs the general dentistry work such as cleanings, x-rays, root canals, fillings and posts while the wife, Doctor Mendoza, does the surgical procedures and inserts the teeth. This first visit cost him \$50.00 total: \$30.00 for the cleaning and \$20.00 for two x-rays. Since it had been years since he graced a dentist's chair his teeth were in great disrepair. He needed 2 root canals (\$200.00), 2 posts (\$200.00), 2 bondings (\$100.00), 3 jackets (\$1200.00) and 1 crown (\$180.00) for a total of \$1880.00. Smirking and shaking his head, Travis recalls,

And the funny thing is that they were going to order my teeth from New Jersey. But I didn't get them from there because they were having trouble getting them from there so they made them in their lab in Mexico and they were just as good. They even gave me a porcelain and metal cap for more strength and biting, so it looks like a tooth but it is metal inside.

The original estimate for this work, written on a plain white piece of paper with the dentist's name stamped at the top, included Procera porcelain jackets made in New Jersey, USA for \$400.00 each; however, when he returned to have the work done on them, the dentist suggested that he use the Mexican version made in a local lab that would cost only \$300.00 each, saving him \$300.00 dollars over the first estimate.

Another benefit is that they would be ready faster than the Procera since they were made locally, cutting out the shipping time. He decided to go ahead and get the Mexican made jackets bringing his new total to \$1580.00 for everything. The jackets were chosen to match the color of his remaining teeth so that they would look more natural and blend in with his own teeth.

While he was in *Los Algodones* for this initial dentist visit, he also went to the eye doctor for new eye glasses. He paid \$95.00 for his eye exam and two pairs of glasses,

including frames, lenses, scratch resistant coating, sunglass tinting on the second pair and cases for both pairs.

I was referred to the eye glass doctor from my friend. I got the [eye] check up - he even blasted me [in the eye with air to test for glaucoma] - and two pairs of glasses including UV coating, scratch coating and the glass case – one regular and one with sunglass coating for about \$100.00. That's the best deal ever. The eye doctor is very nice. He asked about my family when I came back for glasses later. He got very personable, it felt more like family and more personal – even with the dentist, rather than “okay, here you go, thanks” [which is how he feels with doctors and dentists in the US]. The next year I went back again and they were even friendlier, and gave us advice on where to go eat and stuff like that.

We entered Juan's Optical and I greeted the receptionist and explained that Travis needed an exam and glasses. She said that Juan was in the exam room with another patient and it would be a few minutes if we wanted to wait. I said that was fine and Travis and I decided to look at some frames while we waited for his turn. Three of the walls had frames hanging on backlit cases with a few mirrors located in between and one rectangular stand mirror was on the receptionist desk. There are also two rotating stands with more frame options. While Travis looked at frames I also occupied myself by looking at the advertisements on the receptionist desk for colored contacts, transition lenses and designer frames. Some were in Spanish and English, so I practiced reading the Spanish versions to see if I could translate them correctly.

About 10 or 15 minutes later Juan came out of the exam room with his patient. He went to the reception desk and talked with the receptionist who would take the prescription and frames to the lab a few minutes later. When they were done discussing the order, Juan explained to the man that it would be about 2 hours until his glasses were finished, so he should go have lunch or do some shopping while he was waiting and then

come back to pick them up. They said their good-byes and then Juan turned his attention to us. “Hi Juan. How are you doing?”

He shook my hand with his right hand and gave me a hug with his left, “Fine. How are you?”

“I’m fine.” Juan looked at Travis expectantly, smiling, “This is my friend Travis.”

“Hello. Nice to meet you” Juan said as he took his hand and shook it.

“Nice to meet you too,” replied Travis.

“He needs an eye exam and glasses, do you have time now, or do we need to make an appointment for later today?”

“No, no, now is fine. I have time. Come into the exam room.”

This exchange between TMCs and providers is typical. It is in English, friendly, and informal. The introduction of a new patient is also common, as most people go to a provider who was recommended to them by another TMC.

We walked into the small exam room and Juan had Travis sit down on a small round stool in front of the machine that checks for glaucoma and other eye problems by blasting the eye with a small amount of air and allows the doctor to look inside the eye with a concentrated light. Everything looked good, so Juan had Travis move to the larger exam chair which is the typical eye exam chair found in U.S. offices with the recycling style shape and the metallic arm that has the lens device for determining the prescription power needed for one to see well. The standard eye exam chart was projected onto the opposite wall and Travis was asked to read several lines of letters. There was also a part

of the exam where he was shown a pattern and had to tell Juan when they overlapped or when they were next to each other.

Once the exam was complete, Juan ushered us back out to the main room and told Travis to pick out two frames that he liked. He decided to get one pair as sunglasses and one as regular glasses this time, but was also interested in transition lenses. “How much do the transitions lenses cost?”

“They are \$125.00 for the one pair.”

“I think next time I want to get those since I go in and out a lot and then I don’t have to keep changing my glasses.” As Travis was picking out his frames he found some titanium flex lenses that were bendable. Immediately, we thought of his teenage son who had a bad habit of sleeping in his glasses and breaking them. “How much are these frames?”

“They are \$90.00. They are very strong and they don’t break,” Juan said as he took the sample from Travis and began to twist them. We explained that we were thinking of getting them for his son so that maybe he wouldn’t break them as easily. Juan agreed that they would be good for him. So, we decided that we would bring him down with us soon to get those for him even though at \$90.00 for one pair they were pricy, that was about \$35.00 cheaper than at the eye doctor in the United States, and that did not include the eye exam. This was another new U.S. patient that would be coming to Mexico as part of the web of connections that create and sustain the TMC network. Meanwhile, Travis found 2 frames that he liked and handed them to Juan. Then he and the receptionist finished the paperwork and the frame fitting (they took his face measurements to make

sure that the lenses were placed correctly for optimal vision) and told Travis the same information that they told the person before us – it would take about 2 hours for the glasses and that we should go have lunch, shop or doing any other appointments we may have for the day and then come back to pick up the glasses. The receptionist said that it was \$95.00 total for both pairs. Travis handed her a \$100.00 bill. She opened a cash box and gave him his change and then wrote his name and the amount for the glasses on one of Juan's cards as a receipt.

Since I knew that the glasses would take a couple of hours, we went there first, and then we went over to the dentist office for Travis' initial visit. Once we were finished at the dentist we ate at one of the larger restaurants. This one has a live band playing and sometimes people will go up and sing karaoke style with them (especially after a few beers or margaritas). They also serve a unique version of chips and salsa. The "chips" look like funyon pinwheels and don't really have much taste. If you ask, they will bring you a bowl of corn tortilla chips instead. After an entertaining lunch and some touristy shopping we returned to Juan's to pick up Travis' glasses. We walked up to the receptionist desk and told her we were back for his glasses, she asked for his name and then pulled them out of the lab box. Travis tried both pairs on. "They look cool. I can see," he joked. "They look really good on you," I assured him. We said good-bye and walked back across the border to head home.

A couple of weeks later on October 9, 2004, we walked into the dentist's small waiting room area and were greeted by Isabel the receptionist. Smiling she said, "Hello, how are you doing?"

Smiling back, we both replied, “Fine, how are you doing? And how is the baby doing?” (She was pregnant with her first child).

“We are good,” she chuckled. “How are your kids?” (She knew about Travis’ 4 children from their previous conversations).

“They are good, getting into trouble as always,” laughed Travis. The atmosphere is more like friends catching up with each other than a dental office where serious work is about to begin. Again, this provides a sense of humanity to the care giving process that the patients respond favorably to. It creates a sense of loyalty to their providers as well which results in referrals to the offices that they frequent; thus, the doctors receive economic benefits of more business along with the satisfaction of helping someone be healthy.

“Are you ready for your appointment?”

“Yes.”

“Give me a moment; I’ll go tell the doctors you’re here. I’ll be right back.”

“Okay.”

Isabel opened the door to the back portion of the office where the dental chairs and equipment were to let the doctors know that we were there. We stood at the desk chatting with each other and looking once again at the various diplomas and certificates hung on the wall in front of us. A few minutes later Isabel reemerged with Dr. Rodriguez.

Smiling from ear to ear, he approached us and greeted me first as he took my hand into both of his, “Hello. How are you? It is good to see you.” My responses overlapped with his questions, “Fine, how are you? It is good to see you too.” Then he turned to Travis

and repeated a similar greeting. It immediately put us both at ease as we felt secure within a cocoon of friendship. We could trust these people to do good work, because they saw us as people that they cared about and not just a customer. This ritual of friendliness is genuine as they really do want to hear your answers and they remember these details the next time they see you. Over time these budding friendships solidify and become further encouragement for patients to continue to see the same providers. In subsequent visits, we continued to check on Isabel's progress through her pregnancy and the birth of her daughter; information that was freely shared with us. In fact, when I became engaged while working in the field, these dentists and the receptionist from the hearing aid office asked to be invited to my wedding – which they were. These relationships build trust and confidence between the providers and the patients. It appears that many of the patients have a high satisfaction rate with the providers – if they do not, then they will go somewhere else so there are incentives for providers to do good work and keep their clients/patients happy. Travis explained how he saw the difference between the two systems,

I think American doctors and nurses are just out to make a shitload of money and don't become doctors because they care about the patient. They just walk in and see you not even for a few seconds and then bill you. You know they don't really seem to care anymore; you are just a payment number to them. The Mexican system is better because they care more and they take more pride in their work.

During this visit, Dr. Rodriguez completed the root canals, prepping for the posts, the jackets and the crown. Then Dr. Mendoza put in temporary jackets and crowns to hold Travis over until the permanent ones were ready. He also made a payment of

\$800.00 toward his total, “I paid cash. I paid about half and they did the major work and then I came back two weeks later when my teeth were ready and paid the other half.”

Two weeks later on October 23, 2004, Travis returned to the office to finish most of his dental work (it was ready for him a week later, but due to his schedule he was not able to return for an additional week). He paid the remaining balance of \$780.00, again in cash. They removed the temporary teeth and inserted the permanent ones – except for one crown. A week later on October 31, 2004 he returned to have the final crown put in. “The fourth time I went back to the dentist I brought my kids with me and I took a picture with them and they put it up on their board in their office.” The dentists were thrilled to meet his children and took pictures with them (and me) in the courtyard outside of their office in front of the fountain (image 11). The next time I was in town I brought them a copy of the picture which they immediately put up in their waiting room on their small corkboard message center alongside pictures of other patients, and thank you cards and letters. They also allowed me to take pictures of them working on Travis in the dentist chair (I also gave them copies of these so they could use them in brochures if they wanted to).

Approximately six months after he had this extensive work done; Travis developed tooth pain in one of his front teeth, so on April 16, 2005 he returned to the dentist in Mexico once again. I made the appointment for him one day when I was in *Los Algodones* conducting fieldwork. This appointment, like all of the others was on a Saturday since he could drive down on Friday night for the weekend and that way he would not have to miss work. The doctor’s examination determined that Travis had an

infected tooth. Dr. Mendez prescribed the antibiotic Amoxicillin and Firac (a non-narcotic analgesic/pain killer). He was to take 1 of each pill every 8 hours for 5 days. At the Purple Pharmacy he purchased two boxes of 500 mg. Amoxicillin (it came in sealed boxes of 12 pills, so he needed two boxes to fill the prescription) which cost a total of \$11.73 U.S. dollars and one box of 250 mg. Firac for \$7.89 (which only gave him 10 pills, but he felt that would be enough).

A little over a year later on June 24, 2006, Travis went to the dentist for another cleaning (only \$40.00 this time) and to get treatment for another sore tooth. This time after conducting an examination during the cleaning process, Dr. Mendez recommended a mouth rinse called Bexident. It acts as a disinfectant to prevent infection. Travis was to rinse with 15 milliliters 2 to 3 times a day for 30-60 rinses (10-20 days or so). He bought 2 bottles for \$20.40 at the Purple Pharmacy.

After all of these excursions to *Los Algodones* for dentist visits, medication and eye glasses, I asked Travis to reflect on whether it was safe or beneficial to access these services in Mexico. He explained,

Yes, I think it is safe. You just have to watch where you go. Because it seems like the people that I deal with have knowledge of their field. They're friendly, they don't over charge you and they only sell you what you need, they don't try to oversell you. It is easy too, because everybody is referring everybody around there, so if they are good, you know; if they are not good, you know.

People go there [to Mexico] because it is a fraction of the price for the same medicine from the same manufacturers. And the work and services are as good as or better than in the U.S. Financially, it saved me money and it is like a little vacation at the same time. You get to see their culture and get what you need. And I am a lot happier, that is my benefit – I saved money and I have good teeth now. The only drawback is that I wish it was closer.

For someone like Travis who is working class without access to health insurance, going to *Los Algodones* is like an oasis of relief from pain, stress and misery that results from poor health. Here he can receive good quality care from proficient providers at a price he can afford. The relationships he builds with the practitioners increases his trust in their abilities to help heal him which in turn increases his health status. His quality of life was vastly improved with new glasses so he could see, new teeth so he could eat pain free and not be embarrassed to smile in front of others, and the medications needed in the process to prevent or cure infections which contributed to his overall health and well-being. Additionally, he found another benefit, “I went down to see my friend and get some eye glasses and the next thing you know I got my teeth fixed and made some new friends.”

Isaac and Maggie – a snowbird and his daughter

Frequently when researchers present work on healthcare it is focused mainly on the disease, treatment, access, barriers to care, and so on. Often the person as a living, breathing human being is lost. Since so many TMCs complained that they felt the U.S. system had lost their humanity, I decided to try to give Isaac and his daughter Maggie a more human portrait. The following background on Isaac is used to bring a picture of him as a whole person, not just a person with MS, even though his disease is threaded through the description. Their transnational experiences with healthcare in Los Algodones begin in the next section entitled “Medical Access.”

At 24 years old, Isaac, a gregarious adventurer with a zest for life, was flying his first solo flight in order to get his small plane pilot’s license. Born in New York in 1947 as the oldest of four siblings, he lived most of his life in the “Borscht belt” of the

Catskills Mountains; thus, getting his pilot's license gave him an opportunity for new experiences in new places. As he flew the plane, he realized in a moment of horror, that he had lost feeling in his hands. With his ability to control the plane gone, it plunged to the earth in a crash landing that totaled the plane. Fortunately, the collision left Isaac with only a few bumps and bruises. Fearing this would happen again he schedule an appointment with his doctor. During this visit Isaac received a life altering diagnosis – a severe case of Multiple Sclerosis (MS), an incurable, progressively degenerative neurological disease that slowly erodes his ability to control his body. This discovery terrified him. The treatments for MS were not as advanced then as they are today and some doctors were unaware of the steroid therapy being used to treat it. “The doctors I saw in the beginning treated [MS] like a death sentence. One doctor told me that I would be better off dead,” recalled Isaac. At the time of his diagnosis, he was engaged, and at first he was not sure whether to go through with the marriage since he thought he was going to die. His doctor's reaction along with the severity of his case and prognosis, led him to become suicidal. Frightened for his son, Isaac's father convinced him to go to another doctor. This one did not treat MS like a death sentence, and he used more advanced treatments. “He gave me steroids to help treat my MS. He saved my life.” The treatment and the new doctor's positive attitude brought Isaac out of his depression. After working with his new doctor, he decided to go ahead and get married. He and his wife welcomed a beautiful baby girl named Maggie in 1973. Even though he loved Maggie immensely, he decided to have a vasectomy because he was unsure if he could take care of any more children since he continued to go in and out of remission, and he

was worried about passing MS on to them. Shortly after that decision, his marriage dissolved.

Isaac decided he needed a new start, so he moved to Maine and began working on his degrees in psychology. Earlier he earned an undergraduate degree in communications from Cornell University. He continued his education at the University of Maine where he earned his Master's Degree in psychology before becoming ABD (all but dissertation). Having a passion for education and helping people, he became a licensed mental health specialist with sub-specialties and certifications in sexual issues and alcohol and drug addiction. Isaac used his training and life experiences to create programs for people with chronic illnesses using a multi-disciplinary approach to deal with issues that come up with those conditions, such as depression, drug addition, alcoholism, suicide, sexual dysfunction, etc. These programs are still used in Maine today.

While in Maine, and in the early stages of his diagnosis, he was in denial about the disease. Then Isaac met Anne who became a major influence in his life. She too had MS and was not in denial. She saw him walking with a cane and a particular gait and asked him, "Do you have MS?" He was shocked because at that time MS was not something that you talked about, it was secret and carried a lot of shame and stigma. He confirmed her suspicions and she asked him if he would like to work with her at the National MS Society (NMSS). Thus, he began his collaboration with the NMSS in various states. His work became all about working with the chronically ill from that point on. His journey with MS enabled him to help others as well as himself. He was a national speaker for the NMSS and various drug companies. He spoke to people in

various stages of MS and caretakers of those with chronic illnesses about how to deal with MS, interpersonal relationship issues, sexual concerns, denial, etc. This position was perfect for this natural storyteller with a caring attitude. He was able to connect with people on a level different from other caregivers since he too had a chronic illness and experienced much of what they did. He was an inspiration to many and helped them have hope in the face of this debilitating disease. The topics of his talks revolved around the concept that “the disease is a part of you, you are not the disease.”

As Isaac’s denial subsided, he began to research MS and take a proactive, aggressive stance in his treatments. For example, he was one of the first people to take the medication Betaseron once it was approved by the FDA. The new medication had drawbacks, Maggie, his daughter explained, “It was a little too harsh on his system, and it made it difficult for him to control his limbs.” Once, the ungainliness induced by the medication caused him to fall and hit his chin, resulting in 10 stitches. The next drug he took was Copaxone. Isaac was excited about this medication since it lessened the intensity and duration of his disease when he relapsed. By the time they created these drugs Isaac had experienced 20 years of relapsing remitting MS and the disease was quite progressed; thus, even with this new treatment he eventually became “secondary progressive.” This is when there is no remission the disease just continues on its path until it ultimately becomes fatal due to complications caused by the disease. “Becoming secondary progressive is often the case with relapsing remitting MS, especially back then when my dad was diagnosed and when it had progressed so far in him already, so it wasn’t surprising” clarified Maggie. “As his control over his body weakened, he realized that he was going to have to live

more and more in his head. My dad was always a reader, but as his disease progressed, he ramped it up and became voracious.” After having MS for approximately 30 years, he needed a scooter to get around, and then an electric wheelchair. Eventually he became triplegic (both legs and one arm were paralyzed). “At that point he stopped taking the Copaxone and it became all about pain management and quality of life for him,” explained Maggie.

Medication Access

Throughout the past 15 years of his illness, he used various treatments including steroids, high blood pressure medications, high cholesterol medication, Betaseron, 20 mg. Copaxone, 81 mg aspirin, 15 mg. Ditopan, 160 mg. Diovan, 10 mg. Hytrin, 20 mg. Lexapro, 10 mg. PRN Baclofen, 5/300 mg. Vicodan, 100 mg. Provigil, 2 mg. Clonazepam a variety of pain medications such as Baclofen, and Vicoden, an ADD medication to battle fatigue, and an anti-depression medication. Isaac’s income consisted of approximately \$600.00 per month from SSI and about \$500.00 a month from disability. Until 5 years ago he also earned money for his presentations for the NMSS. After his dad passed away 7 years ago, he decided to move in with his mother so that they could help each other. His disease had progressed “pretty far by that time.” This also helped him financially since his medications cost about \$1,000 per month and living with his mom would reduce his non-medication monthly expenses to about \$400.00 per month. His health insurance was a Medicare HMO plan that provided a certain annual amount of money given for prescriptions. This is unusual for Medicare plans since at that time Medicare did not provide coverage for medications; however, this HMO was disbursed through Florida

State which did allot some funds for prescriptions. Even though Isaac lived in New York, he was a snowbird who migrated to Florida for six months of every year. The coverage from this HMO provided for much of Isaac's medication, unfortunately, at about the end of September of each year he would run out of money for medication due to his HMO cap. This meant that he would have to pay out of pocket for October, November and December. Isaac's medication was essential to his well-being; the medications helped to slow down the progression of the disease and added to his quality and quantity of life. Without them he would become sicker faster and die sooner.

Mexico

In 2004 as I was conducting my fieldwork at the U.S.-Mexican Border, I told my friend, and Isaac's daughter, Maggie about people buying prescription medication in Mexico for a fraction of the U.S. cost. Unfortunately, Isaac's disease had progressed to the point where he was unable to make the trip himself so Maggie flew out to California to visit me. We went to Mexico to investigate whether or not she could buy her dad's medication there and if the cost difference would help him buy enough to get through the months that his HMO did not cover.

It was early November as we set out to *Los Algodones* to research the prices and availability of Isaac's most costly medications. What we found astounded us. We walked across the border and entered the Purple Pharmacy as it is the first and largest pharmacy in *Los Algodones*. At the semi-circular glass counter stood the clerk, dressed with a white lab coat over a button down shirt, tie and slacks. He looked every bit the professional pharmaceutical rep. He greeted us in English as we approached. When we

arrived at the counter I asked, "Can you tell us if you carry Provigil in 200 mgs and how much it costs?" After checking in his medication book, he replied, "We do. It is \$100.00 for 100 pills." Maggie and I were shocked. The savings was tremendous. 200 milligram Provigil costs \$10.00 a pill in the United States and he took at least 1 per day for a cost of approximately \$300 per month. We could buy almost 1 year's worth of this brand name medication in Mexico for what it would cost Isaac for one month in the United States. And even more astonishing was the label right there on the package that said "manufactured in North Carolina." That's right; this name brand medication made in the U.S.A. was 10 times cheaper across the border. We also priced his Clonazepam (1mg) medication. This medicine cost \$7-8 a pill in the United States, in Mexico we could buy 90 for \$30.00, for a savings of \$600.00 -\$690.00 for a 3 month supply. "How could that be? How could they charge so much more for it in the United States? For the same medication? Why charge so much more at home when so many cannot afford their medications?" we wondered. Since some pharmacies will compete for your business and have lower prices, we decided to shop around at some of the other pharmacies, such as the Guadalajara Pharmacy, to see if they would be any different. We found that they were the same price in all of the pharmacies.

After finding out the cost savings at several pharmacies, we were so excited that we hurriedly went to the ATM machine to take out cash to purchase them.

Unfortunately, the machine was out of money. "No problem, we'll just go to the one around the corner in the next shop" I said. Of course that one was also out of money.

Unbelievable! So, we ended up having to cross the border back into the United States,

walk to the car, drive to nearby Yuma, Arizona, find an ATM at a local bank, get the cash and then drive back to *Los Algodones*, park, cross back into Mexico and then go back to the Purple Pharmacy to buy the medications. It was unquestionably an adventure. We laughed with each other, “We are definitely bringing the money with us next time!”

While we were there, we also bought medication for Maggie. Her job as a lawyer provides her with medical insurance coverage and with her policy in the United States she pays an insurance co-pay of \$5.00 for one Ibuterol asthma inhaler; in Mexico she was able to buy 3 for \$5.00. She also bought 2 bottles of generic Zyrtec (30 pills) for 12.99 each. Additionally, her insurance did not provide very good coverage for eye glasses or contacts. She was given an allowance of \$75.00-\$100.00 every two years for an eye exam and glasses, with no coverage for contact lenses at all. I told her about the eye provider that I had met personally and that several transnational medical consumers (TMCs) I interviewed went to and suggested that she visit him to see if his prices and services would work for her since she was already here. She agreed, so we walked through a maze of shops and stands to get to the back row of offices where Juan’s Optical was located. As we went in, he smiled and welcomed us in.

Recognizing me he asked, “How are you doing? How is the family?” as he took my hand, shook it and then hugged me briefly with his other arm.

“I’m fine, my family is doing good. How are you?” I asked as I returned the hug and the smile.

“Good.” Still smiling he looked expectantly over at Maggie.

“This is my friend Maggie”

He took her hand in both of his, smiling, “Hello, nice to meet you.”

“Nice to meet you too,” Maggie laughed.

The informality and the personal nature of the greeting, again in English for our comfort, creates a setting of caring and nurturing that makes U.S. customers comfortable and raises their confidence in the services that they are obtaining, so it is important to note.

Looking at both of us, he asked, “What can I do for you today?”

“She needs glasses and a prescription for contacts. How much would it cost for that?”

“What type of glasses do you need, single vision, bi-focal...?”

“I need single vision, but I need to have ultra thin lenses because my prescription is so high that I would have coke bottle glasses without them,” she laughed.

“Okay, we can do that. It is \$80.00 for the glasses – that includes the eye exam, frames, lenses, a protective coating and the prescription - everything. You can also get the dark tint to make them into sunglasses if you want.”

“That sounds great, but I don’t want the dark tint.”

“Do you have time now?” I asked Juan pretty sure that he would say yes since we were the only customers in the office right then. He didn’t disappoint us, “Sure, sure. Come on inside,” he said as he steered us into the small rectangular closet of a room where he conducts the eye exams. It is barely large enough for two people, let alone three, and the two pieces of equipment for the assessments filled each end so there was hardly any room to move. Juan moved to the far end of the room and sat on a stool behind the first machine and had Maggie sit on a small stool in front. She placed her chin and forehead in the appropriate places and then he sent a puff of air into each eye to test for pressure

sensitivity, she passed. Using the same instrument, he looked into her eyes checking for any signs of glaucoma, again she passed. After these two tests were completed, he had Maggie sit in a leather covered eye exam chair that is typically found in eye doctor's offices in the United States. He placed the optical device connected to a mechanical arm in front of her face. Asking her to complete the standard "read this line" and "which is better, this one or this one" as he clicked one lens options into place, Juan finished the exam. Using the notes he jotted down during the assessment, he filled in the prescription for her eye glasses. "Let's go back out to the other room," he said as he opened the door and ushered us out into the larger room where the various frames are hanging on the walls and turnstiles. "What type of frames do you like?" he asked.

"Hmm...Let's see." Maggie, started looking around for a pair of frames for her glasses. After trying on a few pairs, she found one that suited her. Juan took the frames and wrapped them up with the prescription information and secured it all with a rubber band before placing it in a plastic Ziploc bag. His assistant, a not so friendly young woman who was more interested in talking on the phone than helping us, took them and told us they would be ready in two hours. She collected the \$80.00 total from Maggie and handed her a receipt before departing to the lab with the bundle. I was rather put off by her attitude, since I was used to the friendly demeanor of his last receptionist, but I did not dwell on it. Before we left I asked Juan about the prescription for Maggie's contacts. "Are you going to buy them here?" he asked her.

"I didn't even know you could buy them here," she replied surprised looking over at me. Equally surprised, I shrugged my shoulders, shook my head and said, "me neither."

“Oh, yes, we sell them here too and they are very good quality” Juan assured us.

“Thanks, but I am going to buy them back home, I just want the prescription today.”

“Okay, I will write it for you when you come back to pick up the glasses.”

“Okay, thank you.”

“Thanks. We’ll see you in a couple of hours,” I said as we shook hands with Juan and started walking toward the door.

“Sure, fine. See you then.”

“Bye.”

Given that we had two hours to wait, Maggie and I decided to have some lunch at one of the many restaurants dotted throughout the plazas and then do some shopping for souvenirs for her to take home. She found a beautiful piece of stained glass, vanilla, spicy lollipops with bugs in them and a huge bag with a zipper to help her bring everything back home. With her souvenirs in hand, we headed back to pick up her eye glasses.

As I pulled the glass door open for Maggie and me to reenter Juan’s office we could see that more customers had crowded into the waiting room since we left. The few hard plastic chairs lining the outer glass wall were full and a few people were standing while waiting their turn with the receptionist sitting behind the glass counter or Juan who was in the exam room with a customer. We walked up to the glass desktop/counter to see if Maggie’s glasses had come back from the lab yet. After taking a few minutes to check, the receptionist pulled them out of the box used to transport them to the office. She pulled them out of the Ziploc style baggie and removed the rubber band and paperwork

before handing them to Maggie to try on. “They fit perfectly. And I can see,” she laughed. The woman behind the counter handed her a case for the glasses and then I said to her, “We need her prescription for her contacts.”

“Okay, you have to wait for the doctor,” she replied.

“Okay.” We stood, becoming part of the crowd waiting for Juan. When he came out of the exam room he finished giving directions and the paperwork for that customer’s glasses before turning to us with his customary big smile, “Hello,” he said waiting patiently.

“Hi. We need her contact prescription”

“Oh yes. One minute please” and he turned to get a pad of prescription papers and began looking at her paperwork for the information he needed. He filled in the figures needed and then handed it to her. “Thank you!”

“You’re welcome. It is good to see you,” he said taking my hand shaking it as he leaned in to hug me goodbye. He took Maggie’s hand and shook it with his parting farewell as we left the office. We left that day very happy and feeling like we had accomplished something good for ourselves and her dad. (On a side note, I had to go back to his office a few weeks later to get the prescription rewritten because he left off some information that was required for it to be filled at Maggie’s local big box retailer. He gladly took care of it, apologizing for the mistake. I told him not to worry about it and thanked him for fixing it. Then I just mailed the new one to her and it worked just fine.)

Reflections and Impressions

Later that evening I asked Maggie what she thought of her experience buying medications and eye glasses in Mexico. She responded,

It is just such a different environment – it is literally like you are being “hawked” - like carnies who are saying, “Get your medications here” like they are selling popcorn or beer at the stadium. It is such a “flea-market” atmosphere that you feel like someone is going to scam you because it is such a different environment from the one that is idolized and revered in the U.S. where it is made out to be so clinical. I don’t like the “hustle” in Mexico where it feels like everyone wants to be the one to get the American dollar. So part of it is fun and the other part of it is “ugh, enough already.” But buying in Mexico is so accessible and cheap and once you are used to that type of environment it makes it kinda fun – instead of it being a dreary experience of buying medications, it becomes a shopping trip where you can buy a beautiful stained glass piece, a bottle of real vanilla for a \$1 and your medicine which takes out the sterility of that situation and makes it more alive. You are enjoying yourself and you are living; it makes it more human. That is something that is missing in healthcare in the U.S.; that we are human. The healthcare industry has taken out the humanity. We are not just cogs in the machine or just where they get their money from. You almost feel like you have bragging rights when you come home, “You see this pill here, made in North Carolina, only \$1.00 in Mexico; you can’t believe how much I saved.”

I asked her if she thought it was safe to buy medications and get services in Mexico. She stated,

I think it is safe to buy in Mexico, because you literally are getting the same meds, same glasses, and same services that you would get in the U.S. for a fraction of the price. Please see my \$1.00 North Carolina pills [mentioned above].

I don’t know if one medical system is better than the other, but I think [that buying in Mexico] shows what a rip off the medical and pharmaceutical industry really is. There is no reason for there to be such a disparity in prices and if it is because Mexico is a poor nation that they give them such breaks, then there should be a system here in the U.S. that if you don’t have the money for your medications then there should be some sort of sliding scale here as well.

This excursion into the world of transnational medical consumerism was eye opening and life affirming since it allowed Isaac to obtain his necessary medications and thus sustain his health throughout the year, not just for 9 months of it without placing undue stress on him or his family. The fact that he could not make the trip himself and that he and his daughter lived on the east coast meant that they could not easily take advantage of the savings available in Mexico without my help. Thus, social networks are critical to cross-border healthcare practices. Maggie and Isaac's story show how these networks are used to introduce people into this practice, spread information and help them find providers that they can have some measure of trust in due to the experiences of those who have gone before them.

Sadly, almost four years after this Isaac died of complications due to his MS. He was admitted to the hospital and they did what they could before telling his family that he needed to be transferred to a different hospital that was staffed with specialists who could help him more with his condition. Unfortunately, he had to wait until Monday morning to go to the new hospital as they did not admit new patients on the weekend...he passed away at 3 a.m. on Sunday morning. His transfer did not come in time and we lost a valuable human being due to medical bureaucracy. His story is regrettably not unique in the United States. Every day we lose people like Isaac due to a broken medical system rather than a lack of treatment knowledge or skill. We owe Isaac and others like him to find ways to fix this before other innocent people lose their lives for no good cause.

Conclusion

These stories represent the stories of thousands of people just like us. They show the tensions between individual agency providing opportunities for people to meet their needs and the medical institutions in the United States that constrain their access to care. The role that insurance coverage plays in this exclusivity of access is also evident in our tales. The medical and insurance system is restrictive, but people find ingenious ways around the various obstacles to improve their quality and quantity of life. These stories are uplifting because we are finally able to access the care we need by crossing into Mexico. The cross-border strategies offer us relief from pain, disease, stress and a lack of resources. On the other hand, our stories are a sad marker of how people in the United States are suffering due to inadequate health access and the lack of organized and galvanized compassion and community that is needed to resolve these issues.

These narratives bring humanity to this issue, it is not about profit, loss or an economic bottom line for them, it is about quality and quantity of life. These are moving anecdotes that show the human side of this issue. To be sure, economics plays a part in this practice in that one's class and income status often affects the type and amount of insurance coverage and healthcare access one has. Additionally, politics plays a part in how the medical system is set up, maintained, challenged and perceived by individuals as well as the nation as a whole. The feeling of not being cared for in the U.S. system is also a symptom of the lack of compassion that our nation appears to have for those left out, where we blame the victim and suggest that their lack of resources is "not my problem." Social networks play an important part in these stories since this is how

people find out about Mexican care, including how to access it, where to go, who to see, what to do, etc. We, like thousands of others, go because we trust the information from the people telling us about this option which reduces the fear of the unknown that we might experience otherwise (and that might have stopped us from participation in cross-border healthcare). Our positive experiences then solidify our confidence in this practice and the Mexican providers along with our troubled perceptions of the U.S. medical system as profit driven to the point of harming those it professes to serve/help/heal. We are not blind to the positive aspects of the U.S. system, but our exclusion, whether full or partial, makes us disenfranchised from it; so what good does a good medical system do us if we cannot partake of it?

Chapter 5: Risk: Contrived, Perceived, and Real

Introduction

In the previous chapters it is evident that the transnational medical consumers (TMCs) believe that they benefit from their cross-border practices and purchases. Additionally, they use social networks to transmit crucial information on how to access care and supplies in a relatively low risk manner. However, not everyone views this practice in positive terms, especially those who may stand to lose from this medical pluralism at the border. For example, the pharmaceutical companies lose profit when elderly patients buy their medication south of the border. Since the elderly are by far the largest consumers of medicine as a group (PBS Frontline 2003) and the cost in Mexico is considerably lower, so is the profit margin for the manufacturers. While specific statistics of how much profit may be lost due to cross-border medication purchases are difficult to find, the resistance that pharmaceutical companies exhibit against price controls (like other wealthy nations have) and attempts to reimport drugs from countries with price controls (which equals lower prices on medications) as well as their argument that innovation would cease if prices on medications were reduced, suggests that they fear it may be significant (PBS Frontline 2003; U.S. FDA 2002; Kline 2002; Carey 2000; Hiland 2000).

Heyman's analysis of the border as a space where two states endeavor to control and organize actions within their countries and at the nebulous border areas is important to the examination of the tensions between health institutions and care seekers that surround transnational healthcare strategies (1994). Part of the State attempt at control is

the creation of the meaning and images of the border. The border is often constructed as a dangerous space where rules are not always followed or enforced. This image of the border reflects the notions of danger, purity and ritualized incorporation of the margins into the center as discussed by Mary Douglas in Purity and Danger (1966). Medicine as a State controlled ritual incorporates groups on the periphery into the center where they become subject to State control and power. The conviction that the U.S. medical system is the best and is well-regulated whereas others are inferior and not as well-regulated, results in warnings instituted by U.S. medical institutions to caution consumers that purchasing their medications in Mexico may be hazardous to their health. With the aim to stop this practice in order to protect U.S. residents, the Federal Food and Drug Administration (FDA), Department of Health and Human Services (DHHS), some pharmaceutical companies and some U.S. media outlets produce campaigns to inform consumers about the risks of buying their medications and accessing services in Mexico. They warn consumers that buying their medication or seeking their healthcare in Mexico is risky and dangerous because they do not have the same regulations that are in place in the United States. The manufacturing of the drugs along with their purity and quality is questioned. They tell consumers that the medications may be expired, may not be what they say they are, or may be devoid of any 'real' medication at all (placebo/sugar pills) (Garcia 1993; Griffith 2000; Collins 2001; Lunday 2001a, 2001b; Flaherty and Gaul 2003; Osterweil 2004; Associated Press 2004; FDA 2005; Longley 2005; Newsinferno.com 2006). These warnings do not offer information on how to obtain these services in a safe way, instead they present the Mexican system as fraught with

danger so TMCs should just avoid this market altogether for their safety. These ‘risk’ campaigns drawing on images of the Mexican medical system as dangerous and unregulated are designed to help the U.S. medical consumer make better, safer choices by keeping them in the United States where U.S. control is strongest and out of the uncontrolled regions of another system where U.S. control is weak.

While States seek to have power over what happens in this space, the individuals in this area circumvent the State regulations by taking advantage of the flexibility that exists in this marginal space that brings together two different sets of rules and ideologies and thus creates opportunities there that do not exist in the interiors of either nation. Cross-border healthcare is such an opportunity that takes advantage of the two medical systems available at the intersection connecting Mexico to the United States. People who are unable to meet their health needs in their home country can, and do, seek care across the border in the other nation to increase their health status and decrease their risk for illness and disease. Interestingly, the TMCs are not excluding the U.S. system from their medical access process; they are using it when and where they can and using the Mexican system to fill in the gaps. This is a situation where the two systems are articulating together to make one complete system for the TMCs whose ability to obtain care in the United States is inadequate or partial and thus, risky for their overall health. This makes it more difficult for the State to exert control over the populations in this area as their knowledge of the border advantages and their needs motivate them to use the two nations to create a bi-national health care system. Thus, the border crossing populations can be seen as resisting these State forces with their medical choices. These populations are not

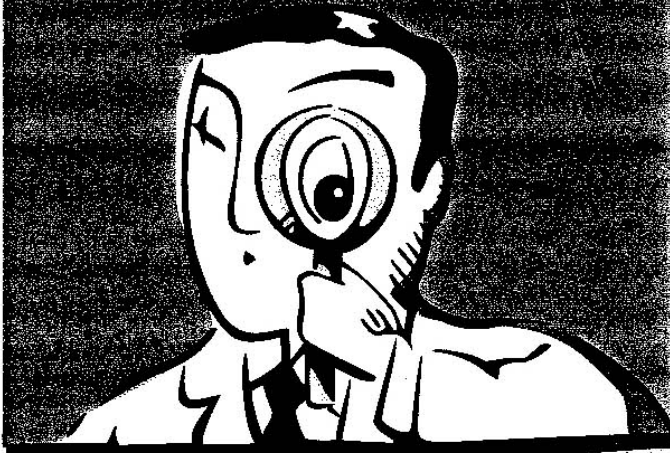
static and bounded in their situations as poor, uninsured and underinsured, instead, they are constantly responding to their situation by using whatever means are available to them to meet their healthcare needs. Thus it is an interactive process between the institutions and individuals/groups which is dynamic and constantly shifting through the adjustments of both the structures and the people affected by and influencing them. Therefore, how the border has been and continues to be created, challenged, and recreated is vital to understanding the mechanisms surrounding this healthcare tactic.

This chapter presents the construction of risk by U.S. government entities and corporations that ultimately obscure the risks associated with the lack of medical care that TMCs face in the United States. Additionally, the perceptions and responses that TMCs have to these constructions of medical risk in Mexico by U.S. medical institutions are examined; including how their community mitigates health threats they may face with access in a different medical system across the border.

Looks can be deceiving.

**The medicine you buy
across the borders may be
unsafe or ineffective.**

Don't risk your health.



**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
U.S. Food and Drug Administration**

**www.FDA.gov/cder
1-888-INFO-FDA**

Image 13: Front of card warning of possible risks for buying medication in Mexico.

Things you should know about purchasing medications outside the United States

Occasionally, U.S. residents travel to other countries to purchase medications (drugs) for personal use or order such medications from foreign sources. The U.S. Food and Drug Administration (FDA) is concerned that medications you purchase abroad may present health risks.

Here's what you should know:

- **QUALITY ASSURANCE CONCERNS.** Medications that have not been approved for sale in the United States may not have been manufactured under quality assurance procedures designed to produce a safe and effective product.
- **COUNTERFEIT POTENTIAL.** Some imported medications—even those that bear the name of a U.S.-approved product—may, in fact, be counterfeit versions that are unsafe or even completely ineffective.
- **PRESENCE OF UNTESTED SUBSTANCES.** Some imported medications and their ingredients, although legal in foreign countries, may not have been evaluated for safety and effectiveness in the United States. These products may be addictive or contain other dangerous substances.
- **RISKS OF UNSUPERVISED USE.** Some medications, whether imported or not, are unsafe when taken without adequate medical supervision. You may need a medical evaluation to ensure that the medication is appropriate for you and your condition. Or, you may require medical checkups to make sure that you are taking the drug properly, it is working for you and that you are not having unexpected or life-threatening side effects.
- **LABELING AND LANGUAGE ISSUES.** The medication's label, including instructions for use and possible side effects, may be in a language you do not understand and may make medical claims or suggest specific uses that have not been adequately evaluated for safety and effectiveness.
- **LACK OF INFORMATION.** An imported medication may lack information that would permit you to be promptly and correctly treated for a dangerous side effect caused by the drug.

Remember, medicines you buy outside the U.S. may be unsafe or ineffective. It's not worth risking your health!

If you have any questions about the use of any medication, FDA encourages you to contact your physician, your local pharmacist or the Board of Pharmacy for the state in which you live.

(FDA) 02-3240

Image 14: Back of card warning of possible risks for buying medication in Mexico.

Risk Constructed

At the end of one of my early visits to *Los Algodones*, I saw the warnings about the Mexican medical system first hand at the border crossing. I was crossing through the border checkpoint back into the United States and had just departed the desk after being cleared by the border patrol agent when I looked up at a plastic holder attached to the wall with information from the border patrol and other U.S. government agencies. A laminated colorfully printed rectangular card about 4 inches by 8 inches in the bottom slot caught my eye. Since it was free information and about health, I took one (see image 13 and 14). It was created by the U.S. FDA and DHHS. The front of the card showed a cartoon character looking like a doctor or lab technician dressed in a white lab coat with a magnifying glass examining two identical looking pills with the statement “Looks can be deceiving” printed and highlighted at the top. Underneath the title it warns that medications in Mexico *may* not be safe or effective, so consumers should not “risk their health” for cheaper medications. The back side presents “Things you should know about purchasing medications outside the United States.” The FDA is worried that the medications may be unsafe and “present health risks” and thus, warn people of the following *possible* issues: “quality assurance *concerns*,” “counterfeit *potential*,” “presence of *untested* substances,” “risks of *unsupervised* use,” “labeling and language *issues*,” and “lack of information” (FDA 2004, emphasis added). These warnings are reiterated and explained further in a FDA “talk paper” where they warn about counterfeit versions of Lipitor, Viagra and “generic Evista” (an unapproved product) by Mexican pharmacies to U.S. consumers (2005). These types of warnings are also distributed to the

general public through various news reports that repeat the information almost directly such as Robert Longley's article "FDA Warns of Fake Viagra, Lipitor and Evista" (2005) and "FDA Warns that Mexican Drugs May Be Counterfeit" on the consumeraffairs.com website (2005). A year later, this same information is used in another article entitled "WHO Pushes for Global Cooperation in War on Counterfeit Drugs" (NewsInferno.com 2006). Earlier versions of these same warnings have also been disseminated through the U.S. media; for instance, Sarah Lunday's articles "When Purchasing Medicine in Mexico, Buyer Beware" in the *New York Times* (2001a), and "Rx, Cheap" in *The Press Enterprise* (2001b). She quotes FDA officials in both articles citing warnings like "...medications from Mexico are difficult to trace and may be manufactured improperly, stored incorrectly, mislabeled or contain an inaccurate amount of the active ingredient" (2001a, 2001b: D1). She also reports that "In January 2000, a government committee found that the average prices for the top five drugs for the elderly were 83 percent higher in the United States than in Mexico. But those savings can be risky, pharmacists at American hospitals near the border said" (2001a). This quote draws on the additional medical authority of the pharmacists of U.S. hospitals; thus, potentially increasing the legitimacy of the risk warning. Moreover, people post articles like these on blogs such as "www.dr.-bob.org" where an article by Amy Collins entitled "Medical Road to Mexico" includes the FDA warnings stated by a spokesman for the pharmaceutical company Merck & Co. in the following quote, "The problem with buying drugs across borders, he said, range from possible counterfeit medications to the reduced supervision for patients. 'Many seniors take multiple drugs,' he said, citing the possibility of negative interactions

among prescriptions” (2001). Again this provides a different voice saying the same message which may give it more credibility to those receiving the advice. The repetitious distribution of these warnings over several years, through various mechanisms, such as FDA talk papers, the FDA/DHHS information card at the border, the newspaper articles, and the blogs also appears to raise the information’s validity since it is so ubiquitous. However, there are some complications that arise with how this risk is being constructed.

Many of these are based on the FDA’s assessment about how and why people are accessing medications in Mexico and their perception of both the U.S. and Mexican medical systems. Some of these views are incorrect and some of these “possible” risks are mitigated by the social networking that occurs among the TMCs. What is missing from the FDA’s assertions is a more complex view of the multiple medical systems in which the patients are engaging. For example, one assumption of the “risks of unsupervised use” is that the transnational medical consumers are buying medications without the supervision or knowledge of their doctors. The types of medications that most U.S. consumers are buying in Mexico do not require a Mexican doctor’s prescription and are thus, legal to purchase over the counter (they still require a U.S. doctor’s prescription to bring up to a 90 day supply back into the United States). It seems to suggest that since it is not necessary to have a Mexican doctor’s prescription for many medications (but not all) to buy them “over the counter,” that U.S. TMCs would just bypass all medical input and just rely on advertising or other non-medical sources as to which medications they should use. While this is often seen with the purchase of antibiotics, this is not usually happening with medications for lowering cholesterol, high

blood pressure or treating arthritis. Usually, TMCs have gone to a doctor in the United States and obtained a prescription for this type of medication before going to *Los Algodones*; this way they know what medication they need, in what dosage and how many pills/doses they need. Furthermore, they continue to see their doctors for follow-up appointments to make sure that their medication is working properly and that it is still needed. Several people I interviewed had gone to *Los Algodones* on the recommendation of their doctors so that they could afford to purchase their medicine. Even though this could be a danger if people were randomly buying medication that was not prescribed to them, this does not seem to be the case for most TMCs; therefore, this risk appears to be extremely low or non-existent for most people I interviewed. One issue that arises from the TMC medication purchases is that they do buy antibiotics to self-medicate as they deem necessary in order to save the reported \$100 or more that it would cost them just to go to the doctor for a diagnosis. This practice concerns the U.S. medical professionals because it is a break in the 'ritual' of U.S. medical procedures. There are also concerns of using antibiotics when they are not necessary, or incorrectly, which can lead to problems of resistance and lower the efficacy of these medications. Therefore the practice of buying antibiotics without a doctor's prescription seems to lead to the notion that all medications would be bought and used without medical supervision. Both the economic concern of bypassing a doctor visit and the medical concern of medication efficacy are important and valid; the solution is not necessarily clear, or easy, although many would argue that if medical care was less expensive and more available then most of the problems would be solved. Understanding that many people will buy their

medications and services in Mexico anyway, educating consumers on when to use and not use them could also help reduce these concerns.

This raises questions of what knowledge is considered reliable and valid, who should have control over medical consumerism, whose responsibility is it to ‘warn’ consumers of the risks, how are the risks determined (i.e. just because they exist, does it mean you should not use the system at all, or does it mean that you become an educated consumer?), what is at stake for those supplying the medications and those buying them? The economy of *Los Algodones* is dependent on the TMCs coming initially, returning for more work and supplies, and through word of mouth getting others to come as well. If they sell ‘bad’ medication or do poor work then the TMCs will stop coming and their town would all but cease to exist. The providers rely on these customers, so they need to make sure that their products and services are good quality or they will not be sustained economically. In 2004, Mexican authorities were investigating accusations of fake or inferior medication was sold in “at least one” *Los Algodones* pharmacy (Associated Press, 2004). The Associated Press reported that “It was unclear whether the problem was widespread. There have been isolated reports of fake medicines in the past, but none large enough to halt the flow of Americans seeking cheaper healthcare in Mexico, estimated at 15,000 crossings daily in the busy winter months” (Ibid.). Since a reputation for selling “bad drugs” could destroy this town’s economy, the providers are vigilant in rectifying and reducing such incidents. The town supervisor for *Los Algodones*, Jorge Cochran stated that, “The pharmacy owners meet every two weeks to look at these kinds of situations and to make sure everybody is charging the same prices” (Ibid.). The social

networks support this as well through word of mouth warnings and recommendations. It is important to note that this information is shared freely with anyone considering cross-border access, whether friend or stranger, including through on-line chat rooms such as seen in chapter three.

I need to clarify here, that I am not suggesting that there are not real risks, or that buying medication in Mexico (or anywhere else for that matter) is always safe; however, I think it is important to note that all medical systems have risk to the patients and that these risks are present in the U.S. medical system as well. Therefore, the question is how do the TMCs reduce their risk or address these issues of risk to reduce their harm. Additionally, the issue of risk is tricky, since the reason many of the TMCs are accessing care in Mexico is because they are excluded from access in the United States, so an important question is what is riskier, buying medication and services which may *possibly* be substandard or dangerous, or not accessing them at all which could result in lower quality of life and/or possibly death. Furthermore, the experiences of these consumers indicate that these risks are minimal and can be avoided, especially when the information provided by doctors and the social networks is taken into account.

The issue of risk also revolves around perception. How much risk or danger influences decision making depends on the actor's perception of the level of harm they think they are facing, from where and if there are ways to reduce it. Ideologies surrounding medication and healthcare are fraught with ambiguity. The pharmaceutical companies and doctors support the idea that medications are necessary and important for people's health, yet access to these resources is limited by the ability to pay for them.

This can result in a strong belief that the medication is essential for survival or at least for the relief of suffering, making it worth pursuing. Therefore, if the consumer believes that medication or procedures will improve their quality and in some cases the quantity of their life, and they can access it through a proven method of cross-border access, then no amount of attempts to warn them away will work. This is especially true when their experience and observation override the vague warnings by U.S. institutions. TMCs are circumventing the structural violence of an inaccessible system where the risk of not accessing care is higher than the risk of accessing it in an unorthodox manner, especially when others have gone before them and have had good results. Thus, they perceive the warnings from the various institutions and media to be evidence of the greed of the medical system, the pharmaceutical companies, the insurers, and in some cases, the doctors in the United States. They view the U.S. governmental system as corrupt when it comes to dealing with these access issues, and putting profit ahead of people (see chapter 3 and 4). So even though these institutions may see their warnings as an attempt to protect people from harm, it comes across as them acting as handmaidens to the greedy medical system that excludes them from care – so how could it care about them, if it won't grant them access to the procedures and medications that they need to live better and possibly longer lives? It is contradictory and comes across as insincere. Thus, the TMCs are angry at the U.S. system and feel that they are hopeless to change it; however, they can take matters into their own hands as individuals and access their care in Mexico. This also plays into their perceptions of Mexican providers as more caring than their U.S. counterparts since they are finding a way to allow them access to the inaccessible in the

United States (so one system excludes them and presents this as acceptable, while the other makes room for them and shows them compassion). This is reflected in their statements about how the Mexican system has brought back the “humanity” to their care that the U.S. system has lost (chapter 3 and 4).

Is it safe?

Since one’s perception of potential threats and harm is critical to the decision making process of TMCs, it is important to understand their views of the Mexican medical system in terms of safety. When asked if they thought it was safe to buy medications or get care in Mexico the TMCs I interviewed overwhelming said yes (table 5.1). The majority also stated that they did not think that there was a difference between the medications available in Mexico and the United States (table 5.2). Ryan explained “No, I haven’t found any difference [between the medications].” He buys both brand name and generic medications in Mexico and on the day I interviewed him, he and his partner bought medication made by Baja Medical, GlaxoSmithKlein, Novartis and Collins (a Mexican manufacturer). Most TMCs agreed and made comments like Bill and his wife who stated, “No, we never noticed any difference.” Several remarked that the medicine sold in Mexico was from the same companies that sell medication in the United States. For instance, Wendy stated, “No I don’t [think there is a difference between medications]. Advair here is GlaxoSmithKlein and is the same company in the U.S.” Tony agreed, “No. They are from the same pharmaceutical companies. I think the U.S. is money hungry, just like cigarettes and liquor [are more expensive in the U.S. than in Mexico]. And taxes are added to everything – state, federal, sales.” Chrissy adds, “Just

like my asthma and Advair inhaler – they look exactly the same. The only ones that look different are the ones written in Spanish.”

Table 5.1: Is it safe to get medications or care in Mexico?

| Answer | Percentage |
|-------------------------|-------------------|
| Yes | 82% |
| No | 9% |
| Don't Know/Can't Answer | 3% |
| No Answer/Not Asked* | 6% |
| Total | 100% |

*Two of my preliminary interviews with snowbirds did not include this question so I do not have answers for them.

Table 5.2: Any difference between medication from the United States and Mexico?

| Answer | Percentage |
|-------------------------|-------------------|
| Yes | 4% |
| No | 83% |
| Don't Know/Can't Answer | 13% |
| Total | 100% |

Personal experience and observation, particularly over time, plays a fundamental role in the perception of safety and risk for the TMCs just as it does for their perception of medication being the same in both countries. For instance, Wendy states, “I have been doing it for 12-13 years [without a problem].” Margie concurs, “Yes, [it is safe]. My husband has been doing this for over 20 years. No problems, the businesses are still here, I have no qualms whatsoever.” Barbara stated, “Yes [it is safe.] I have friends who have been doing it for years [without any problems]. [The pills] come in the same bottle, in English, sealed.” Harry is confident with the medication he buys because many of the people who live in the RV Park with him take them and as he observes, “I haven’t found anyone lying around the RV Park dead yet” due to “bad stuff” or medication from Mexico. So, based on their own observations and experiences they conclude that they are

safe. This personal experience also works for those who have just begun to participate in this practice like Alice who states, “Yes, it has been safe so far. I’ve not had any problems.” Jessica, who just purchased her first medication in Mexico since she has insurance coverage in the United States for her prescriptions, has the perception that it is safe to do so based on the experiences of those with experience in this system. She explained, “Yes. From what I’ve heard, yes [it is safe]. I really can’t verify it [since she has not taken her medication yet], but I hear yes. People come back year after year.” She continued to use other people’s experiences to support her view that it was safe when she stated, “I can’t say if there is a difference [between the medicine], I just bought it [in *Los Algodones*]. But according to the other people, they keep coming back, so it must be okay.”

Tony feels that it is safe to buy medications and get services in *Los Algodones*, “Because most [providers] are trained in the U.S. Everyone we know has not had any problems.” He explains that they are a little “leery” of buying medication in Mexico since they have not bought it themselves, “but we have not seen any problems. If the medications were less expensive, I would buy here to try it out. My mom bought one of her prescriptions here [in *Los Algodones*] and it was 2 times the milligrams she needed, so she broke it in half.” Karl states that “If you buy brand names and check the expiration dates [on the packaging, then it is safe]. We buy 10 -12 medications here [in *Los Algodones*], including Cumatin, Izar, Medforman, and Topitral (Amatryptaline), but there are 3 that we can’t get here because the drug companies won’t sell them to Mexico.”

Lu, a snowbird, touches on three other factors that makes TMCs feel comfortable – the ease of the transactions, a lot of fellow countrymen and English speaking providers.

She said,

It is very safe. *Algodones* is completely taken over by Americans – not like *San Luis* where there used to be a lot of Americans, but not anymore. The doctors, dentists, and pharmacy clerks all speak English [in *Los Algodones*], so communication is easy. At the Guadalajara pharmacy there are 10 girls in white coats waiting to help you behind the counter. You tell them what you need and they fill it and then the cashier rings you up and then you are done.

Cautions and Concerns

As I conducted my interviews, I came across people who did not access care in *Los Algodones*. Some were visiting for lunch and tourist shopping, some were with friends who were accessing healthcare, but due to their perceptions or insurance coverage they did not participate in the transnational medical consumerism themselves. A few did not access care in Mexico because they did not trust the providers there, or were worried that if something went wrong there would be no recourse to rectify the situation. This view was the exception, not the rule in *Los Algodones*. In my research I rarely came across anyone who was unhappy with buying medications or obtaining services in Mexico, but as we see below some did have negative experiences. Some are vague about why they are uncomfortable with the Mexican system; for instance, Sheila simply stated that, “No, [I don’t think it is safe]. I’d be reluctant. I’d be hesitant.” She also explained that since she and her husband had not bought any medications in Mexico as of yet that they could not say if it was safe or not, “I think that’s the problem, we don’t know,” she stated. Others articulated issues of trust in the system and the providers as critical to their

perceptions of risk and safety. Grace explains that she has a general view that medical care outside of the United States is dangerous, so it is not necessarily just about Mexico specifically. For example, she stated that she was in Japan for 9 years and only obtained medical treatment on the military base, “because you don’t know” about medical care in foreign places. She also complained, “Medications are expensive [in Mexico] according to what kind you buy,” which contradicts the pricing information gathered during my fieldwork and reported by other TMCs. This appears to be an attempt to support her minority viewpoint that people should not buy medication there. The possible language barrier also concerned her, “You don’t know the language, so you don’t know what you are getting. You have to take their word for it too, so that is another thing that scares me.” She also believes that there is a difference between the two systems as she explains, “There has to be [a difference], don’t you think? They are not trained as well, maybe, but I don’t know, I couldn’t say. I trust them at home [in the United States], they may not be all that great, but I trust them at home. It is probably the same no matter what country you are in” meaning that people probably trust their home system, no matter where it is. Finally, she shared that she had a negative experience when she did buy her medication in Mexico. She purchased her high cholesterol medication and it made her sick both times she took it. The first time it made her nauseous, and the second time she vomited, so she stopped taking it. Now she won’t buy any medications in Mexico – she doesn’t trust them, because she feels they will make her sick. Understandably, I think this is the major reason for her distrust in the system and this ties in with her concern over the language barrier as she may feel she couldn’t communicate effectively with the

provider to ensure her medicine was correct. She also expressed her confusion over Canadians buying medication in Mexico, “I don’t understand why Canadians come here, and Americans go to Canada too, why do they come here [Mexico]? It’s dumb! I guess they figure the medications are okay, I don’t know.” She surmises that the Canadians and Americans who go to Mexico haven’t had a bad experience like she had. With her adamant distrust of non-U.S. medical systems in general it is interesting that she was willing to try the medication in Mexico in the first place. This could be the influence of so many TMCs who have successfully bought their medications there, making it appear less risky until her negative experience reconfirmed her original viewpoint. As seen in chapter 3, the chat room discussion showed a couple from Washington state who had a bad experience and would not buy in Mexico again. The husband commented, “We bought my wife’s prescriptions like [others in the discussion] and my wife is lucky to be alive. We buy from Canada now and the same as we buy in the USA. We know a large amount of RV’rs buy in Mexico with good results so we might just be the one that wasn’t lucky.” Interestingly, they note the fact that they know “a large amount of RV’rs” who buy their medications there without a problem, so they acknowledge that they may be the exception to the rule. Their negative experience means that their trust with this system was broken and they will not venture to take that chance again, but they don’t completely discourage someone else from going there, they just share their caution due to their experience. Almost as if they are saying, “Be careful or this could happen to you.”

Social Networking

Offering cautions and advice is one of the functions of the social networks that TMCs belong to. These cautions help increase safety and reduce risk. Harry warns that you “Also have to be aware of dentists who might be trying to do things that don’t need to be done; for example, filling cavities that don’t need to be filled, just to make extra money. It is best to get references from people who are happy with their care.” This same type of comment was made by Travis about eye care providers, “We walked by this one eye glass place the guy looked ‘sketchy’ I had no confidence walking into his door. He looked like he bought a machine and said he was an eye doctor.” He also explained that he chose his providers through “Word of mouth, people would give you advice – go to that guy, don’t go to that guy he doesn’t know what he’s talking about. You need to talk to someone that lives there or has been there because they let you know that there are people who don’t know what they are doing no matter what field they are in, just like in the U.S.” These comments by Travis and Harry allude to the trust that exists in the TMC community where the recommendation of a TMC is highly regarded by another TMC. A chat room member from Alberta, Canada also provided support for the practice with a caution in his statement, “From what I saw last year, a lot of drugs in Mexico were the same stuff (Brand Name) as in the U.S. and Canada. I think you’d be safe buying the Brand Names. Off brand stuff, on the other hand, would worry me a little...” Karl noted, “Not if you get good brand names, then they are okay. There were some problems this past year with generics that were fake, but we don’t think it was widespread.” Carrie, a TMC who I interviewed said, “One thing that a friend ran into – I never have – was that

one of her asthma puffers was empty. I always have the [number of] pills that I am supposed to.” She contrasted this with her experience in the United States, “Rite Aid does not always have the right amount in the bottle; I was often 4 pills short. I hate them with a passion.” Some had negative experiences with their provider or medications in other Mexican border towns. Ryan commented that,

I have never had a problem. I bought medications here [without a problem]. I know some who have had problems. I’ve heard that *Tijuana* and *Nogales* are bad. I heard that here [in *Algodones*] and *Juarez* no one has had a problem. Possibly due to economic reasons, *Tijuana* and *Nogales* are dirty cities [meaning corruption]. They are playing it like anyone would – if you can get away with it you will do it, it is human nature. [Additionally,] I don’t think the dentist in *Nogales* was honest with me. He did bad work. I need both upper and lower plates, and I asked him if he did these and he said yes. He may have helped that along [with his bad work].

Carrie mentions her view of the difference between *Los Algodones* and other cities, “Not that I have found. I’ve found the results to be identical in those I bought in the U.S., but I’ve not bought puffers [inhalers] here [Mexico]. My son-in-law did and had a problem with it, but I think he bought it in *Tijuana*.” Her doctor told her not to go to *Tijuana*, but to go to *Los Algodones* instead because “it’s safer.” It is important to note the perception of *Los Algodones* as safer in comparison to other Mexican border towns/cities such as *Tijuana* and *Nogales*. Again, this may be due to the different local economic foci of each city, with *Los Algodones* concentrating on medical and dental services.

Medical Authority and Quality

The role of the U.S. doctor and pharmacist as people with medical authority supporting this practice as safe and less expensive is vital to understanding why some TMCs believe that cross-border access is a low risk venture. Many TMCs reported that

their doctor and/or pharmacist suggested that they go to Mexico; some even specified *Los Algodones*, in order to buy their medications at more affordable prices. Since these TMCs trust their U.S. providers, their recommendation transfers a measure of trust to the Mexican system, given that they don't believe that these medical professionals would tell them to go there if it was unsafe for them to do so. This also points to another area of ambiguity in the U.S. system. The doctors and other medical professionals want to help their patients, but they too are bound by the access that their patients are able to obtain; thus, if the patient cannot afford the medication that they need, the providers are unable to grant them access to the necessary resources, so they do the next best thing - they point them to another system that will grant them care. For instance, snowbirds Bill and his wife purchase Prilosec and heart medication in Mexico because their doctor said it was safe and their U.S. pharmacist recommended that they buy it in Mexico since "it is cheaper there." They do not buy his wife's glaucoma drops there because she "wasn't sure about it and Medicare took care of it." Rick and his wife were also introduced to buying medication in Mexico through the recommendation of their doctor in order to save money. They buy their high blood pressure and high cholesterol medications, Thoratoz, Acoritiz, and Penicillin in Mexico. Rick states that they are the "same pills, identical, but cheaper" so he feels confident taking them. However, at first their doctor's approval did not quell all of their fears about accessing medicine across the border, especially since they had a counter view expressed in the local media.

The first time we came [to *Algodones*] just to visit. We didn't realize how cheap it was so we went ahead and filled our prescription, but we weren't comfortable at first, but now yes. The first time we bought our medicine here we didn't feel real good about it because of what you hear on the

news – they prefer that you don't buy down here. [But] if there was a problem this little town wouldn't exist. It would be highly publicized, their business would deteriorate. And you can buy from Canada, I haven't, but they're cheaper [in Mexico]. If I had a serious disease I wouldn't take a chance with my life.

Harry explained that he listened to a radio talk show where a Canadian pharmacist was being interviewed and he said that in that interview he heard that 80% of the U.S. pharmaceutical companies' manufacturing is done in Europe and then dispersed to the United States and sold to Mexico and Canada. He believes that the pharmaceutical companies in the United States are pushing claims that the medications are not the same quality in Mexico, but he is not finding anyone sick by them. Harry then offered some "common sense advice" to anyone buying medication in Mexico, "Overall, I don't think there is [any difference]. But there is human corruption everywhere, it is human nature. If you take the medication and it doesn't seem right, then don't go back there [to that pharmacy]." A Canadian snowbird, Jake, stated that his medications come in the same box as he gets at home in Canada. Additionally, he volunteered in a pharmacy in Sun City and talked with the pharmacists about purchasing medication in Mexico many times and according to him, they say the medications in Mexico are the same. He explains, "If Pfizer puts medication in a box it is the same in the U.S., Canada, etc. It is still from Pfizer." He also mentioned that there are no drug advertisements allowed in Canada, unlike in the United States, with the implication that this may impact pricing in both countries. These examples show how the personal experience and observations of TMCs in addition to the medical professionals' recommendations have solidified their perception that it is safe to buy their medications in Mexico.

Another way that medical authority in the United States is used to support this practice and counter safety warnings is seen with the following examples. John uses medical services in the United States to verify that his Mexican medications are effective. When asked if there was a difference between U.S. and Mexican medications, he said, “I don’t think so. I used to buy them in *Nogales* for a kidney problem in the beginning [when he had no healthcare coverage] now I have health insurance, so I buy it in the States.” He took the medications he bought in Mexico to a doctor in the United States and he checked them out and said that “they were okay.” As a retired nurse Nancy has her own medical authority and knowledge. She explained that from her perspective there is no difference between U.S. and Mexican medications, “Not from my way of thinking. I worked with a pharmacist (in the United States) who did not have a problem with it. If he says it’s okay, who am I to dispute it? I don’t have a problem with it.” A pharmaceutical representative she worked with said the company had analyzed medications from Mexico and that it was “not as potent and had rat turds and hairs in it.” She laughed and said that her only problem would be if they were not as potent, she could care a less if there were rat droppings and hairs in the bottle. She also did her own “experiment” where she figured that if her thyroid medication was not working or effective then she would know it by a simple thyroid test. She went to her U.S. pharmacist and had him check her thyroid levels after using the Mexican medication. Her levels were fine, so that proved to her that the medication was effective. Additionally, she went to her doctor and told him that she was considering buying her medications in Mexico and he told her that was fine, except for her cancer drug. Chrissy

shares a similar experience, “I’ve never had any trouble, and like with my thyroid, when I have the lab work done my levels are right [with the Mexican medications]. When I hear on the news that it’s not safe I think the drug companies are trying to scare people because I’ve never had trouble with the medications I get.” She, like Nancy and John, is using lab tests conducted in the United States to verify that her Mexican bought medications are working like they should. The reality that some U.S. medical professionals are recommending Mexican health services to their patients also contradicts the cautions and warnings that come from the institutions like the FDA, DHHS and some media sources about access in Mexico as “potentially” dangerous or as occurring without U.S. medical supervision.

As described in chapter four, at least some of the medications and medical and dental supplies come from the United States. For instance, Isaac and Maggie were buying a medication that was made in North Carolina and my hearing aids were made in Florida and Travis’ teeth could have come from New Jersey. Although I was unable to verify this assertion, Nancy’s uncle told her that Pfizer owns the Purple pharmacy. These observations are important when it comes to concerns over the quality of medical devices and pharmaceuticals sold in Mexico. Is the rhetoric suggesting that the U.S. companies supplying the medications, teeth and hearing aids to those in Mexico are sending substandard items? Or are they suggesting that since they are not sending all of the medications and supplies that others are sending substandard provisions? Or is it that once these goods are in Mexico it is such a corrupt place that one cannot be sure what is done with the legitimate substances? This raises further questions about drug

manufacturing ‘purity’ and quality issues since many medications are made in off-shore production factories in countries outside of the United States. This includes medications sold in the United States. In fact, Joel Lexchin, M.D., associate professor in the School of Health Policy and Management at York University in Toronto, Ontario, Canada reveals that several countries may provide the chemicals for the manufacture of medications in both Canada and the United States (Osterweil 2004/5). He comments, “When you buy a drug in the United States that is supposedly manufactured in the United States, it may have been tableted or made into a cream there, but the ingredients that are in there may have come from a variety of different countries, and the FDA does not consider that those are unsafe” (Ibid.).

Media and Risk

While the media plays a role in informing people about the cross-border practice in general, it also plays a role in raising alarms about the alleged associated risks (Garcia 1993; Griffith 2000; Collins 2001; Lunday 2001a, 2001b; Flaherty and Gaul 2003; Osterweil 2004; Associated Press 2004; Longley 2005; Newsinferno.com 2006). Nancy commented on the media’s role in influencing cross-border access, “A lot of people are throwing scare tactics [about buying your medication in Mexico]. Have you heard about the guy who bought 300 tablets of valium?” She was referring to a newspaper article entitled “Quest for Cheaper Drugs Can End in a Mexican Jail” on page A1 and “Cost of Cheap Mexican Drugs Can Be Jail Time” on page A15 that was about Americans arrested for buying medications in *Tijuana farmacias* (Kraul 2004). The article explains that over an approximately year and half time period at least 67 Americans were arrested

in *Tijuana* for buying medications without a prescription from a Mexican doctor which would be an average of 3-4 people per month. In a city with 1,300 *farmacias*, it seems remarkably rare that a TMC would face that problem; however the headlines of the article suggest otherwise. This ‘scares’ some potential U.S. consumers from buying their medications in Mexico for fear of being arrested and thrown into a Mexican jail. What is left out of the articles is that those who were arrested were attempting to buy controlled substances in Mexico without a Mexican doctor’s prescription. The types of drugs they were purchasing include classes of drugs that are considered narcotic, such as sleeping pills like Ambien and pain pills like Valium. Additionally, if the purchaser had a prescription from a Mexican doctor then he/she could legally buy them in Mexico in certain quantities; they would of course, then need a U.S. doctor’s prescription to bring up to a 90 day supply into the United States. Most *Los Algodones* TMCs appear to be very aware of the rules to buying medications in Mexico as evidenced by Nancy’s statement above. Even Lu cautions, “But you can’t get narcotic type of drugs like Valium because it is illegal to cross the border with it. Well, I don’t really know since I don’t use that type of drug, but that is what I hear.” Furthermore, the pharmacists in *Los Algodones* don’t want that type of reputation, and so they will tell you that you cannot purchase that type of medication without a Mexican doctor’s prescription. For example, as part of my fieldwork I went to several pharmacies asking how much the sleeping aid Ambien cost. All of the clerks told me that I could not buy it in their stores, except for one, and he told me that I needed a Mexican doctor’s prescription, which I could obtain in his pharmacy for \$40.00 (many pharmacies are said to be run by Mexican doctors so

this is a common service that is provided). Additionally, during my entire fieldwork experience in *Los Algodones*, I never met, interviewed or heard of anyone being arrested there for purchasing medications there. The article even states that in *Tijuana* only an average of 7 people from the United States per *day* are arrested, most for drunkenness and disorderly conduct, not for buying prescription medications at local *farmacias* which as we see above averaged 3-4 per *month*. Interestingly, the *Tijuana* Pharmacists Association is worried that these arrests will damage *Tijuana*'s reputation and drive away potential customers. This may be one of the reasons TMCs talk about other cities and town in relation to *Los Algodones* as dangerous and "dirty" since there appears to be the danger of being arrested, even though it is slight, most people would not see the point in taking the chance when they can go to *Los Algodones* without that concern.

Real Risk

Though it may seem that the risks touted by the media and some U.S. medical institutions are groundless, or perhaps not as prevalent as they would have TMCs believe, there are some real dangers associated with accessing care in a different system than the one you are used to. Primarily it is important to watch out for erroneous assumptions that may occur due to the fact that both systems are biomedical models therefore they must work the same way. They don't, and the risks that I observed and experienced came from people not being very aware consumers of their medications or service providers. Lu, a 69 year old snowbird migrant who lives in Yuma, Arizona during the winter and Kansas the rest of the year, is a very experienced transborder healthcare seeker. She explains, "You write down the medication and take that with you into Mexico and they [the

pharmacy clerks] are very proficient with their medical books and will find your medications for you.” Though she cautions,

There could be [problems]. You have to have medical knowledge – [like about] the side effects of medications. Most of the pharmacists in the U.S. will tell you the side effects when they give you the medication, and they will do that in Mexico if you ask, but if you don’t ask, then they probably won’t tell you. If the patients are not paying attention to the dosages and side effects, it can be dangerous - like if you are supposed to take 5 mg of medication, but the pills you get in Mexico are 10 mg instead, you have to cut it in half when you take it or you will take too much. So you have to pay attention because that would not happen in the U.S.; they wouldn’t do that.

Her cautions about knowing the milligrams of the medication in comparison to the prescription are significant since this can impact the effectiveness and side effects that a person would experience. Additionally, one needs to know if a medication can be broken in half and then taken since some medications, such as those that are time released, cannot be safely consumed when broken in half. It is also important to note that some medications come in smaller dosages than the prescription so the patient would need to take more than the original number of pills indicated in order to receive the full strength prescribed. Thus, access in this system requires a working knowledge of your medication, dosage, side effects, drug interactions, and so forth in order to safely purchase and consume your medications. This level of consumer of knowledge is not required in the United States since it would be provided by medical professionals automatically as part of the system. When someone takes their medication and becomes sick it may be due to a misunderstanding or lack of knowledge due to different expectations of medical system operations and the assumption that biomedical models are the same everywhere. This lack of knowledge is not an insurmountable problem; in fact,

it is often mitigated by the social networking that occurs among the TMCs. Since so few TMCs reported problems with their medications, it would appear that this risk is reduced through shared knowledge among the network.

Another issue that can happen is seen in one of my early fieldwork experiences. A friend and I were walking through *Mexicali* when we stopped inside a pharmacy so I could see if they sold Bextra, and how much it would cost. Shortly before beginning my fieldwork I sprang my back and could hardly walk due to the pain. My doctor gave me some samples of Bextra and told me that it was a relatively new and expensive pain relief medication. It was about \$1.00 per pill in the United States. Since it was new and according to my doctor expensive, I wanted to see if it would be available in Mexico, and if so, if it would be cheaper. The pharmacy was a small, non-chain store that was jammed with shelves of containers and boxes of medications, herbs and “health products” labeled in Spanish. This was not a pharmacy geared toward U.S. TMCs, it was for the Mexican locals. The small room appeared to be about 5 feet by 10 feet and was subdivided into two spaces with a shelving unit and a desk that blocked the “back” area from the front customer area. The customer area included a glass counter with a register and pharmaceutical guides and notebooks strewn across it. As we entered, there was a middle-aged woman standing behind the counter. I explained that I was looking for Bextra. She did not recognize this medication so she looked for it in a rather beat up copy of a paperback pharmaceutical guide. The guide itself did not inspire confidence as it was missing its cover and was torn into three pieces that were stacked on top of each other. After about 3 minutes of looking through the book for the medication, she asked

me to wait and then went into the back of the store to ask another employee about it. A new woman, signaling her medical status/authority with a white lab coat, came out with the first woman. She nodded a greeting to me and then began searching for Bextra in another copy of the guide which was in the same deteriorating condition as the first. After about a minute of searching she told the first woman to hand her a bottle of Celebrex and then told me that it was Bextra. I was surprised to find out that they were the same medicine. So I asked them just to make sure that I understood them correctly, “Bextra and Celebrex are the same medicine?” The woman in the white lab coat said, “Yes, they are the same.” The bottle they showed me was 100 pills of 200 milligrams of Celebrex. I asked how much it cost. They started discussing the price in Spanish; first the woman in the lab coat told the other woman that the bottle was \$95.00, then after seeing the look on my face indicating that I was not going to pay that much for medication, told me in English it was \$85 for 100 pills. Since I was not sure that the medications really were the same and I did not plan on buying any pills for that much money, I said, “I’m just pricing them right now” which is a standard comment that TMCs make to pharmacists in *Los Algodones* since they often shop around. *Los Algodones* pharmacists are fine with this practice and do not bat an eye at that statement, but here, these women were displeased, so I added, “I do not have that much money on me right now. Thank you for your help. I will have to come back another time.” It turns out that it was a good thing that I did not buy the medication at that time. On my next trip to *Los Algodones* a few days later, I approached a pharmacist standing behind a large glass

counter in the Purple Pharmacy. He too was wearing a white lab coat. I asked him, “Can you tell me if you carry Bextra or Celebrex?”

“Which one do you want?” he asked.

“Aren’t they the same?”

“Well, they are the same class of drugs, but Celebrex comes in 200 milligram dosages, and Bextra comes in 10 and 20 milligram dosages.”

I was shocked. While I was pretty sure that Celebrex and Bextra were probably not the same, I had no reason to doubt that the other pharmacy would give me such incorrect information. This is probably one of the ways that people get sick from buying their medications in Mexico. However, it is important to contextualize my experience and the pharmacies. One, the pharmacy that I went to in *Mexicali* was a small, non-chain one so it may not have been as reputable as the larger chain store I went to in *Los Algodones*. Second, the women in the first pharmacy clearly did not know what Bextra was, but the second pharmacist did, he did not need to look either medication up in the pharmaceutical books that he had in front of him, which were in tremendously better shape I may add, so he may have had more experience and knowledge of these two medications. Third, *Los Algodones* is very dependent economically on providing medications and services to TMCs so they work hard to have knowledgeable people in these positions, while *Mexicali* is a large urban area that is not so reliant on this type of service so the quality control may not be as strong there as in *Los Algodones*.

The danger of these issues is somewhat alleviated by the socialization and networking that occurs between the transnational populations. The previous experience

of friends, neighbors, family and healthcare professionals who know the second system is used to educate ‘newcomers’ in the process of accessing their care in the second system. Where one purchases medical services and supplies seems to be important as well, judging from the comparisons of *Los Algodones* to other towns and cities such as *Nogales* and *Tijuana*. Thus, one has to be a savvy consumer to purchase medications safely in Mexico and part of that is being a well connected member of the TMC community.

Better System

Even with the perception that Mexican medication and services are relatively low risk, when asked if they thought that one medical system is better than the other and if so, why, most responded that they believed the U.S. system was the best although there is also some ambiguity in their explanations. For example, Phyllis commented that, “The U.S. [medical system] is the best in the world. My husband is a heart patient. He has had bypass surgery and 4 stints. I have had knee replacements. The advances in medicine are great in the U.S. and it keeps getting better, improving. These advances cost a lot of money, but they are highly sophisticated.” Ruefully she adds, “But you need medical coverage or you won’t get the high cost care.” Ryan, a Canadian snowbird, compared the U.S. system to Canada’s, “The U.S. has far superior service. As far as medical care, there is no difference. The U.S. has faster service than Canada because Canada is socialized medicine, so unless you are on death’s doorstep, you wait for your care. If you are on death’s doorstep then care is immediate.” He then gave the example that you could wait 6 – 9 months for heart surgery unless it was an emergency; this is the same in Mexico. Chrissy added, “I think that the U.S. is probably better, but here [in Mexico]

they are well educated, but I still rely on the U.S. – I never go to a doctor here [in Mexico], a dentist, but not a doctor.” Even Grace who showed immense distrust in the Mexican medication shows some ambiguity in her perceptions of care in Mexico when she states, “The U.S. [medical system] is better than Mexico. Dental is fine in Mexico. If you lived here then it would be different [you would get good medical care].” Her daughter-in-law and others that she knows get medical care in Mexico, “they trust them [their providers],” she shrugged her shoulders after that statement as if to say “it’s their choice and/or risk” so it is not her problem but theirs if they want to risk their health, but she would not make that choice. Rick remarked, “I don’t know anything about Mexican insurance programs. I am not happy with what I have [in the United States], it is very expensive and they penalize you – if you get ill I am sure they will cancel you. [For example,] if you have chest pain – there is no coverage if you have a heart attack for 3 years and no one else will insure you.” Carrie notes, “Probably not. There is a twofold reason that it is more expensive in the U.S.: 1. we’re paying for research, Mexico is not; and 2. Mexico is considered a 3rd world country and drug companies sell to them cheaper.” Maggie replied, “I don’t know that they are better. I think it shows what a rip off the medical and pharmaceutical industry really is. There is no reason for there to be such a disparity in prices and if it is because Mexico is a poor nation that they give them such breaks, then there should be a system here in the U.S. that if you don’t have the money for your medications then there should be some sort of sliding scale here as well.” This view of the U.S. system as better than the Mexican one supports the notion that TMCs would rather access their care here if they could. It seems then a waste of time

and money to try to stop this practice by pushing the idea that Mexico is inferior or unsafe. Instead, it would seem more productive to seek ways to grant the TMCs access in their home system which would ultimately stop the cross-border practice as it would become unnecessary.

Risk in the U.S. System

Even though the FDA and DHHS put out repeated warnings of the risks of Mexican medications and services, it is important to note that some of the possible risks listed by the FDA are inherent in any medical system, including the one in the United States. For example, the concern over “counterfeit potential” is an issue in the United States medical system. In 2001 the pharmacist Robert Courtney was charged with 20 federal counts of tampering, adulterating and mislabeling drugs. He diluted cancer medications for chemotherapy (particularly Taxol and Gemzar) and pocketed the profit. This resulted in cancer patients receiving a lower dose of the medication than they were prescribed. He did this for 9 years (since 1992) before he was caught. It is believed that this led to many unnecessary deaths, but it is difficult to prove since cancer patients are at a risk for dying already. This circumstance may have actually helped him get away with his deceit for as long as he did since no one realized that these patients were not getting their full treatment dosage. One indicator was that they did not experience the awful side effects that usually accompany these medications, but the patients thought that they were just lucky to be avoiding those complications. The companies that he bought his cancer drugs from, Bristol-Myer and Eli Lilly, were also charged since it was believed that they should have noticed that he was selling more of the drugs than he was buying. In fact,

about 3 years before he was investigated by the FDA and the FBI, a drug representative did notice that he was selling more than he was buying and told his superiors at Eli Lilly. They did their own investigation and could not determine where he was buying his additional medication. They assumed he was buying it from the 'gray market' which is where "legitimate" drugs are obtained outside of the closed supply chain or tracking system, usually at a discount so they did not notify the FDA of the discrepancy – this is why they are being charged along with Courtney (Belluck 2001a, 2001b, New York Times 2002, Draper 2003:2). This raises the question that is often attributed to Mexican medications: how does anyone know what is in the drugs or whether they are expired or not? Many also expressed that this was the only case of its kind in the United States, as though it could not be happening here on a regular basis, just because no one is getting caught; but Courtney did it for nine years without getting caught so that does not seem to be a very good indicator of whether it is happening more frequently. Additionally, a New York Times article explains that

Courtney understood the peculiar vulnerabilities of his victims and of the professional world he occupied. For all his nefarious extracurriculars, he never strayed far from the drug industry's self-described "closed supply chain," overseen by the Food and Drug Administration, which refers to itself as a regulatory "gold standard." Still, drug company officials themselves estimate that 10 percent of the pharmaceuticals traveling through the closed supply chain are counterfeit. Meanwhile, the industry's pre-eminent sales research organization, IMS Health, concedes that its data capture only "roughly 70 percent of all prescriptions dispensed in the U.S." With so many drugs unaccounted for or fraudulently introduced, Courtney could rest assured that it would be nearly impossible to track his dilutions (Draper 2003:3).

This type of fraud could be, and probably is, happening much more often than suspected.

The only reason that Courtney was caught was because a pharmaceutical representative

made a comment about his discrepancies to a nurse who worked for a doctor who was buying her cancer patients' medications from him and she told her doctor what she heard. The doctor then sent some of the drugs she had bought from Courtney to the lab for testing, they returned showing between 1 and 39% of the medication they were supposed to have. She then notified the FDA who started an investigation. They had the doctor order two more rounds of medication from him which they tested and received the same results. From there they arrested Courtney, who at first denied any wrong doing. Later he confessed and said he did it "out of greed" even though he was worth over \$10 million at the time of his arrest (Belluck 2001a). In the end, prosecutors "...believe he diluted 98,000 prescriptions, issued through about 400 doctors, potentially affecting about 4,200 patients" (de Vries 2002:1). He received a sentence of 30 years in federal prison (Draper 2003:1). Since only about 70% of prescriptions dispensed in the United States are examined and even the drug companies think that at least 10% of drugs are counterfeit, I think it is naive to think he is the only one doing this in the United States. This can also be tied to the FDA concern over the "presence of untested substance" since it is unclear what is in the counterfeit drugs believed to be circulating in the U.S. medicine supply. Furthermore, labeling issues are present when this happens since the counterfeit drugs are mislabeled as seen with Courtney's case (this is essentially the main charge he was arrested for and convicted of).

Counterfeit medication issues overlap with the risk of "quality assurance concerns" that are included in the warnings against Mexican medication. This includes medical knowledge, skill, authority and patient safety. Again, this "concern" aimed at

the Mexican medical system is also present in the U.S. system. Gabriella's story is a prime example. In 2002, Gabriella was pregnant. At first it was a normal pregnancy but then she started to experience bleeding.

I was spotting and people told me that it was nothing, not to worry about it. But it kept going on, so I decided that I needed to go to the doctor. I went to a doctor in La Jolla. He was highly recommended by several ladies I knew through the La Leche League. He was an older man, in his 60s or 70s, so he seemed to have a lot of experience and he even told me that he had "seen it all." He ran lots of tests and did blood work and sonograms/ultrasounds – but he could not figure out what was going on. I had so many ultrasounds, almost every time that I went in to see him I had one.

They explained to me that the blood work gave them my hormone levels, and that these tell them how far along in the pregnancy you are. The range is very small so they believe it is very accurate. They thought I was about 6 weeks along at my last ultrasound, I think, and said that they needed to see a heartbeat to make sure that everything was okay. I was very confused by that, it was my first baby and I was feeling very pregnant. I was vomiting, tired, and everything. So I did not understand why they thought I might have lost the baby. They explained that I could still have those pregnancy symptoms even if I had lost the baby because I still had the placenta and would still be releasing hormones which would cause the signs of pregnancy. So, they did a vaginal sonogram, and did not see a fetus.

In the meantime, between visits Gabriella did her own research and concluded that her hormone level determined by their lab tests indicated that she was two weeks earlier in her pregnancy than they said she was. When she told them this, they said, "No, that was not it." She explained, "They completely rejected my idea." Instead, the doctor recommended that she have a D & C to avoid infection and help her feel better. She asked them, "Are you absolutely sure?" The doctor replied, "I'm so sure I will do the D and C in the afternoon tomorrow." Understandably, she was very upset. "I requested one last ultrasound before the D & C. I just wanted to make sure. They said okay." It was

scheduled on Thursday the day before the D & C which was scheduled on Friday.

However, on Thursday, the radiologist office called her and said that they were behind and wanted to reschedule her ultrasound. She said that was fine and called the doctor's office to cancel the D & C until after the new sonogram appointment.

Meanwhile, her mom came up from Mexico to comfort her during this "time of tragedy." Seeing her daughter's strong misgivings about the miscarriage, she suggested that Gabriella go see the doctor in *Tijuana* that she used to visit when she lived in Mexico. "I think they have Saturday appointments" her mom said. He did, so they went to see him that Saturday. She told him the whole story of what had happened with the first doctor and he said, "We'll see what we can find out." He felt her uterus and said, "You feel pretty pregnant." Then he did an ultrasound in his office (he had the machine right there, she did not have to go to another office or make another appointment to have it done, or get the results) and miraculously there was a heartbeat. "There's your baby," he smiled, "Your pregnancy looks normal, very normal, because of your symptoms and everything. You look great." She was so happy and relieved, but also upset with the first doctor.

I called the other doctor on Monday and told them I was very upset. I had asked if there was a small chance that if they miscalculated the age of my baby and they did not seem to pay enough attention to my questions. They seemed to want to get rid of me. It was my first pregnancy, I kept asking a lot of questions and I don't know if they were not used to it, but they did not seem to like it. My experience with doctors here [in the United States] is that they want to go much faster, but in Mexico it feels like the doctor gets to know you, that they care more. I couldn't believe that they wouldn't just sit down for a few more minutes and listen to me, or consider that there could just be a chance they could be wrong. It seemed like they just wanted to get rid of the problem.

She felt that she was more informed than they were, or perhaps than their average patient since she did research on hormone levels to understand what they meant. Their response to her was, “We are so glad that you found out before you had the D & C.” There was no apology, no remorse, and no regret. Disappointed she explained, “I never went back to them. The doctor in *Tijuana* – he is great, if I was living closer I would just have stayed with him because he is really, really good. But it was too far.” So instead, she found another doctor in United States who she stated was the complete opposite of the first one. She had a great experience with the new doctor and in 2003 she gave birth to a beautiful, healthy daughter.

The main difference she noticed between the two U.S. doctor’s offices was that there were more Latino people in the new office, than the other office in La Jolla where she did not see as many Latinos. Otherwise, there was no difference between them. They were both private practice doctors through Scripps La Jolla. She concluded, “I cannot tell you that I have gotten better care in the U.S. To me the main issue is that they want to rush you out of the office – when you want to slow them down by asking questions, they don’t like you.”

Gabriella’s experience with her U.S. doctor raises quality assurance concerns, since this doctor misdiagnosed her as having miscarried and as being further along in her pregnancy than she was. He was thought to have great knowledge and skill in his field, came highly recommended by other patients, and yet in her case made a horrible mistake. Luckily her Mexican doctor was able to rectify that mistake before it cost a human life.

The cases of Robert Courtney and Gabriella are only a couple of examples of the same risks that patients in the United States face that the FDA and DHHS warn TMCs about accessing care in Mexico. These risks are in every medical system to some degree. The problem is that the frequency of these events in Mexico (or anywhere else) is not presented to consumers, so the warnings become useless, vague, scare tactics instead of useful information that could protect them which is the presumed goal of the risk campaigns put forth by the FDA and DHHS. This is particularly true since these warnings are contradicted by the TMCs experiences and observations.

Conclusion

Through all of the above examples and data all of the issues attributed to buying medications and services in Mexico have been dismissed, reduced or shown to be an inherent risk factor in any medical system. Risks are inherent in every medical system. Even though there is oversight and regulation in the United States, we see people falling prey to greedy pharmacists, incompetent or impersonated doctors, unethical medical practices and even sociopaths who tamper with medications (i.e. Tylenol poisoning). The problem is that though these risks are present, it is unclear how frequent they are in any system. These warnings to TMCs about Mexican medication and services do not come with statistical information on how high or significant the risk is, so it comes across as a vague warning at best and a scare tactic at worst. It is possible that one could be a victim of this problem, but there is no way to gauge the likelihood of this happening. Therefore, a person's perception of risk plays an important role in determining how safe they feel in each system. Their trust or mistrust of the institutions and those providing the

information on the risks also influences their belief of the severity of the problem. These risk campaigns are perceived by many TMCs as scare tactics produced by “greedy” profit driven medical industries. Therefore, if they see the FDA and DHHS as supporting, or in the pocket of, the ‘greedy, profit mongering’ pharmaceutical companies then they are not going to heed their warnings of dangers when buying their medications in Mexico (see chapter 3). However, if a fellow TMC tells them to be careful of a particular medication or pharmacy they will pay attention to that and use that information to avoid possible danger. It is a matter of trusting the information provider, one’s own experiences, and observations balanced with their needs and the risk of not getting care (or the level of suffering from not getting care, such as tooth pain). Additionally, the border towns that are reliant on selling medications and services to U.S. TMCs see the need to ensure patient safety to the best of their ability so that they do not lose their market and their livelihood (Associated Press 2004).

Based on the statements of the TMCs it would appear that the risk campaigns waged by the U.S. FDA, DHHS and some U.S. media reports do not dissuade most from utilizing the Mexican medical system when they deem it necessary to access life improving and sustaining medication and supplies. This strategy is not effective in ending cross-border healthcare access/practices, since it does not take into account the realities of this practice/process. Furthermore, by attempting to limit their ability to obtain health resources in Mexico without providing access in the U.S. system they are participating in the structural violence against the TMCs by impeding their access to these essential resources and the TMCs know it – this feeds their anger and distrust of the

medical industry in the United States (chapter 3 and 4). Especially since the TMCs' experiences and observations prove otherwise. TMC Chrissy is happy with her access in Mexico, however, she states that, "If drug companies would stop advertising and cut prices, then I wouldn't do it [buy medications in Mexico]." This again points to the fact that many U.S. TMCs would purchase their healthcare and supplies in the United States rather than in Mexico if they could access it there. Therefore, if these institutions really want to stop this practice, it seems that reducing the cost of pharmaceuticals, dentistry and eye care and/or increasing insurance coverage for these items is necessary. This would significantly diminish cross-border access since most state that they would prefer to obtain these in the United States if they could.

Chapter 6: Conclusion

Introduction

As I conducted my interviews and participant observation along the U.S.-Mexican Border in 2002, 2004 and 2005, I saw people from both nations accessing care on both sides of the border; however, it became very apparent that the larger obscured story was that of the U.S. residents who lacked access in the United States gaining it in Mexico. Based on these observations I decided to focus my dissertation on the Transnational Medical Consumers (TMCs) from the United States who accessed care in Mexico. The types of services they obtain and the reasons why are directly tied to insurance coverage, economics, proximity to the border, ability to travel to the border and social networks. Their stories reflect the tensions between a large, bureaucratic, and exclusive medical system that is set up for profit and the individual agency that is pushing people to satisfy their medical needs by whatever means is available to them. For the system, it is about profit, for the person, it is about their quality and possibly quantity of life. Two very different motivating factors pushing and pulling in one composite transnational system suspended in a web of ideologies contextualizing the actions of both. Ideologies such as individual responsibility, supply and demand, growth and competition, health and safety and risk management frame the actions of the individuals crossing the border to obtain care in another country; the U.S. medical institutions such as the FDA and DHHS that try to maintain public safety; the Mexican care providers who gain income by providing services for those with unmet needs; the pharmaceutical companies and medical providers that lose profit when people obtain their care in another country for less; and

the insurance providers that are adapting to the fluidity of the people and the border region. The complex discourse of risk becomes even more nuanced in this context. Those losing profit suggest that the medications and services in Mexico are subpar and thus dangerous to those who acquire them there; yet, they ignore the dangers faced by TMCs due to their exclusion from the U.S. medical system. This also assumes that people in the United States have a choice between the two systems and that they are choosing to go to Mexico instead of the United States. For most, the choice comes down to access in Mexico for these resources or no access at all. My dissertation research combines the knowledge, theories and analytical models of globalization, transnationalism, border studies, and critical medical anthropology into a comprehensive macro- and micro-level understanding of cross-border healthcare. Using these frameworks, my research at the U.S.-Mexican Border illuminates how healthcare access in both countries is embedded in the political economic configurations of resource allocation.

Structures of Access and Exclusion

Critical Medical Anthropological (CMA) approaches to exploring healthcare attempt to understand the structures that shape and formulate health conceptions, technologies and care access. Like other political institutions, medicine is "...filled with power struggles and efforts to control individuals or social groups" (Baer et al 2003:8). Cost and profit alongside institutional regulations and medical hegemony play pivotal roles in controlling health access, practices and perceptions. Considering health as either a commodity to be bought and sold or as a human right to be guaranteed to all is part of

the political discourse on these vital resources as well. Therefore, it is important to locate medicine and health within the capitalist world system using a political economic approach. For my work on transnational healthcare at the U.S.-Mexico Border, this means looking at the macro-level of institutional responses to this cross-border practice, including how insurance companies, the FDA, the U.S. Border Patrol, congress, laws, the pharmaceutical companies, medical practitioners, the media and the medical establishments on both sides of the border react to these cross-border practices by the individuals, in the context of what Singer calls “Global Drug Capitalism.” This refers to how drugs are made in one country, sold in several by corporations headquartered in another; thus, they are true transnational companies (Singer 2008:10, 11). My work also examines the micro-level of the individual agency in the people who cross the border to access healthcare, how and why they do it, their beliefs and reasons for doing so, the economic and insurance issues surrounding their decisions and their health outcomes with the practice.

Approximately 45.7 million people in the United States are uninsured, and many more are underinsured which means that they lack access to the health conferring resources available to those who can afford them in the U.S. system. Their exclusion from these critical assets can, and often does, have devastating effects on their quality of life and can reduce their quantity of life as well. Their suffering could be alleviated by the power holders who shape access and public opinion, such as the U.S. congress, FDA, DHHS, insurance companies and pharmaceutical companies through a variety of mechanisms. These institutions and companies could lower the cost of medications and

other technologies, but they say that they cannot or else the innovation in these areas would cease (or at the very least slow down to an unacceptable level). They could raise insurance coverage and change some of the rules to include everyone, but they say that the companies cannot afford to do so since that would put them out of business (due to the high cost of care). Furthermore, if the government tried to offer a public option they say that the quality of care would decrease and the wait time would increase; plus many balk at using their money through taxes to pay for “someone else’s healthcare” since some suggest that if everyone were covered, then no one would have an incentive to take care of their health to avoid needing care.

The power that medical institutions such as these have to control the legislation that governs access and the perceptions of the U.S. system, as well as other systems, appears to constrain individuals in their pursuit of care. However, while the legal and political power struggles continue, individuals need access to care now; they cannot wait to see these issues resolved. My data shows one important way that TMCs, as at risk populations, alleviate their suffering and meet their medical, dental and vision needs. By crossing the border into Mexico they circumvent their omission from the U.S. system. Mexico is providing opportunities for TMCs to acquire these medical resources at rates that they can afford, while the United States is trying to figure out what to do about their medical access issues. My research demonstrates how the border acts as an articulation point for cross-border care strategies connecting the medical structures and institutions of both nations as people cross the border daily to take advantage of the distinctive opportunities available there that are not necessarily obtainable in their respective

interiors. Throughout its history, the U.S.-Mexican Border has performed multiple functions as a barrier, gateway and fluid space between the two countries and cultures. Additionally, the population growth along both sides of the border has increased the political, economic, cultural and institutional connections in this region. This area is thus perfectly situated, historically, politically, economically and socially for cross-border care practices to emerge and continue for as long as necessary (see chapter 1).

Economically transnational healthcare is a win-win for both the TMCs who are able to obtain their needed healthcare and the Mexican border towns like *Los Algodones* that are able to build their economy by providing medical and dental services for them. This strategy is supported by trade agreements such as NAFTA that help to open the borders to more types of trade. In the 1990s investment in private health services increased in Mexico to accommodate the growing market for U.S. healthcare consumers (Arredondo-Vega 1998:166-167) and as a result many TMCs that I interviewed began accessing services at that time (see chapter 3). Medical care and services work as a commodity in the United States to be purchased rather than a “...basic survival resource in which people have an inherent right...” (Singer 2008:139) as in Mexico. Even though the economic draw to save money may appear to be the main rationale for U.S. TMCs to go to Mexico, there is another critical reason why they are going there – they are obtaining the resources that they are excluded from in the U.S. system. My research with the TMCs reveals how they use both medical systems to construct one transnational configuration that encompasses the services and supplies that they need to survive and thrive. They access the care they can in the United States and then fill in the gaps by

going to Mexico. Some chose the Mexican system over the U.S. one due to their perception that the providers there are more caring and see them as people rather than an insurance card number, and most are happy with the care they receive in Mexico, still many TMCs say that if they could access their medications and services in the United States they would prefer to do so (chapter 3). People, thus, attempt to maximize their health and well-being and overcome their lack of access in the U.S. system by articulating the two different medical systems to form one pluralistic transnational structure that effectively provides them with what they believe they need to improve their health and quality of life.

While the medical systems are being constructed according to each nation's ideologies on the positioning of health, the TMCs are also being shaped by the access patterns that they employ to meet their needs. In the United States they are the poor, uninsured and underinsured at-risk populations, in Mexico they are transnational consumers overcoming their marginal positions by obtaining vital resources to improve and maintain their health. This bi-national medical pluralism creates a transnational population of health seekers who organize themselves in social networks that share crucial information on how to negotiate the two systems for optimal results. Thus, TMCs and their Mexican providers are transnational populations forming 'deterritorialized' communities in the fluid border region and beyond.

As discussed in chapter 2, these populations gain experience in accessing these medical resources in Mexico that they turn into "cultural capital" and share among their "social networks" which in turn expands the communities of TMCs. One of the most

intriguing aspects of their cross-border networks and practices is how they are developed as a “mode of resistance” in response to the “asymmetries in the global marketplace” of healthcare as well as to the inhospitable medical environment they find in the United States. This resistance is critical to their survival since they do not have the necessary economic resources to access some or all of their care in the “for profit” model operating in the United States. Mexico in this case is providing a subsidy to the U.S. healthcare system by providing for those who are left out in the United States. This allows the U.S. system to remain selectively prohibitive and doesn’t require it to make adjustments for those barred from its services. It also allows the profits in the medical industry to continue at their current rates.

Interestingly, the TMCs are not the only transnational part of this picture. The drug corporations are also transnational. They manufacture their medications wherever is cheapest, they sell them worldwide and respond to the pricing rules of each nation so that the socialized medicine countries with price controls on medication pay less than the United States for the same products. These global drug markets along with economic limitations results in the push/pull of consumers in response to medical needs. This pushes the poorer patients into markets where they can pay less for their medications; thus, as we see above making the patients transnational. These transnational economic pushes and pulls create new medical markets in Mexico for those who cannot afford to access their care in the United States. For instance, *Los Algodones* became the “Mecca of Medicine” by providing the services, such as pharmaceutical drugs, needed by the TMCs, including lower prices and English speaking workers to attract that particular market of

potential transnational consumers. Therefore, medicine and healthcare can be perceived as a “value” or “commodity” to be shifted between the core and periphery where the periphery can offer care at a rate that is more affordable for those from the core with less economic resources.

Traditionally, medical pluralism is defined as the presence of two or more medical systems in one culture. It is often conceived of as a combination of biomedical models with ‘alternative’ forms of health and healing that provide multiple medical choices for the patients (Singer 2008). In these cases medical pluralism would be seen as taking place at the institutional level with individual actors making their medical choices from the options provided to them by their cultural institutions. My work at the U.S.-Mexican border, demonstrates a new type of medical pluralism – one created by the individual actors as they crossed the border to use more than one medical system.

Additionally, both medical systems accessed by these patients are biomedical models. Interestingly medical pluralistic systems appear to reproduce the hierarchies in the larger society with “alternative” options holding less status and power than biomedicine (Baer et al 2003:11; Singer 2003). Since both options are biomedical models this hierarchy may seem to be irrelevant; however, it is recast as a hierarchy between nations and culture, regulated and unregulated systems, pure and tainted, core and periphery so that the power and status differentials remain. These two biomedical models are competing with one another for medical consumers and markets.

This competitive hierarchy between the two nations is reflected in the U.S. medical institutions ambiguous responses to cross-border healthcare practices. For

example, private insurance companies in the United States are the most common access point for people to obtain care; however, they often restrict access due to the high cost of policies, the amounts of deductibles and caps and the restrictions on tests and treatments. They can also cancel a person's policy if they become too sick (and thus too costly to the company's profit margin). Yet as much as they may restrict access in the more costly U.S. system, my research shows that they also see the cost saving advantages to lower cost care in Mexico, and thus offer border insurance policies to those living in this area. Often these policies have lower co-pays, or no co-pays, due to the less expensive care and medications available across the border. They also have lower premiums which allow some employers, who may not have been able to provide health insurance to their employees, to offer these plans to their workers; thus, potentially increasing those covered by insurance and able to access healthcare. Furthermore, government insurance plans such as Medicare and Medicaid provide some access for their recipients, but many resources such as dental work, eye glasses and medications were absent from coverage or inadequately covered, leaving holes in their care that they could not afford to fill under the U.S. pricing system. The out-of-pocket expenses for co-pays or full price medications and dental work were too high. So while the government plans helped the populations using them, they were insufficient. Pharmaceutical companies have a somewhat ambiguous role in healthcare as well. On the one hand they provide the medications that can improve and in some cases extend a person's life; on the other hand, they are profit driven companies that restrict access to these resources based on the ability to pay for them. Additionally, they sell the same medications to different countries at

extremely different prices. The price controls in Mexico (and Canada) make the same medication that is priced out of the reach of many U.S. consumers affordable across the border. This causes many TMCs to see the owners/operators of these companies as inhumane, callus and greedy since they appear to be putting profit before people (at least in the United States). These ambiguous roles and responses contribute to the pushes and pulls of TMCs and their transnational health strategies.

Other institutions are not so ambiguous in their stances toward health and cross-border access. For example, the U.S. FDA and DHHS have worked with the media to produce information to warn TMCs of the possible dangers associated with Mexican medical access. The problem is that their warnings are vague and littered with phrases that point to the possibility of the risk, but not a concrete level of danger. The stereotypes and ethnocentric notions of the United States having a better care system than Mexico make it inconceivable that people would reject care in the United States and seek it there. These assumptions are intimately tied to the negative, pejorative views of Mexico as a struggling country fraught with corruption and poverty. Though there are risks in cross-border care, social networking binds the TMCs together as a transnational community and provides invaluable information on the safest way to navigate the unfamiliar Mexican medical system. Knowledge then becomes a type of currency and commodity as TMCs share their experience of the border, how to access care, where to access it, safety concerns and how to deal with them, etcetera with those left out of the U.S. system. This is part of what connects them as a population as they share sympathy, empathy and concern for each other and help one another negotiate the new system. This is a type of

resistive power that TMCs have against the hegemony of health institutions in the United States that allows them to obtain resources outside of U.S. control. This, along with the relationships that they build with the providers, raises their confidence level with the Mexican system and makes them perceive the FDA and DHHS as handmaidens to the greedy pharmaceutical and medical companies. Additionally, the threats that they warn against are present to some degree in all medical systems, which further weakens their credibility (chapter 5). The positioning of these institutions and TMCs show the tensions surrounding healthcare in the United States and the strategy of cross-border care access. Thus, the structural violence of exclusivity that constrains the access to health conferring resources in the United States, and the warnings presented by institutions to stop cross-border practices while not providing a viable alternative, negatively impacts individuals' health statuses while protecting the profits of the medical industry.

States vs. Pharma

Not everyone in the United States is disregarding the plight of the uninsured and underinsured. Some U.S. states are trying to help their at-risk populations such as seniors and the poor access medical resources. For instance in 2000 the state of Maine observed the incredible savings that seniors were receiving by taking bus trips to Canada to purchase medications, much like the tour bus trips that TMCs make to *Los Algodones* for the same reason. Chellie Pingree, a member of the Maine Senate from 1992-2000 reported that in the previous three bus trips seniors had saved over \$105,000 on their medications. That spurred the Maine legislature to craft a bill called "Maine Rx" saying that pharmaceutical companies had to sell their drugs to Maine for the same price that

they were selling to Canada in order to try to save their seniors money on this resource and cut out the necessity for the bus trips to do it (which would further reduce their medication expenditures by eliminating the travel costs). The pharmaceutical companies took this seriously and sent lobbyists to Maine with the sole purpose of killing the bill.

Senator Pingree explained,

And one of them actually passed us a note during the debate that said, "Based on the position the two of you are taking, you will never receive any more contributions from us." And that was the amazing thing. I mean, I was the majority leader of the Senate. They were basically saying, "You can't pass this law in the state of Maine" (PBS Frontline, 2003).

In May 2000 the Maine Senate passed the bill unanimously and almost unanimously in the House, so the bill was about to become law. However, the pharmaceutical companies did not give up; they filed an injunction to stop the law which they saw as a move toward government price controls of medication which could significantly cut into their profits. Marjorie Powell, a PhRMA (the pharmaceutical companies' trade group) representative explains, "We don't think the government should be setting prices and telling companies what they can charge. We think that prices should be set through the market, through negotiations. That's the way the private sector negotiates" (Ibid.). The seniors did not see it that way. Senior activist John Moran clarifies, "It's pure and simple greed. The drug companies always had their way, and it's very, very difficult for them to give up that position. Even though they gave it up in Canada and throughout Western Europe, they held onto the position that they could charge whatever they wanted to in this country for their meds and get away with it" (Ibid.). The legal wrangling, lasting over 3 years, went all the way to U.S. Supreme Court which found in Maine's favor with a 6-3 decision,

allowing the bill to go into effect. This concerned the pharmaceutical companies even though Maine is a small state and the impact on their profits would not be great, but this opened the door for other states to follow suit (Ibid.). In the end Maine's victory over the high prices of medications for their seniors and poor, could provide the entire nation's at risk populations some relief from a lack of access to these life conferring resources.

Maine's Rx law is not the only way that states are trying to ease the financial burden of high priced healthcare. Oregon uses another approach. Governor John Kitzhaber (1995-2003) realized that in one budget cycle the amount spent on medications for Medicaid recipients rose over 60 percent. This meant that with less money to spend, fewer people would be able to have coverage for their care. At the same time, he had an employee who was prescribed Celebrex for pain in his wrist rather than the less expensive Ibuprofen which would have been just as effective with a net savings of about \$68.00 per month. Thus, Oregon's Governor was inspired to craft legislation to provide a type of consumer reports for doctors to provide them with information on a drug's efficacy and price in comparison with other drugs of the same class. It turns out that most doctors obtain their information on medications from the very pharmaceutical companies that produce and sell them. This often means that the representatives will recommend the newer, more expensive drugs rather than the older, cheaper ones, even if they are both equally effective. This also ties in with an underlying notion that newer is better, which in the case of medication is not always true as many new drugs are reconfigured old drugs (PBS Frontline 2003). Therefore, the goal was to give doctors reliable, accurate information that could help them decide if the less costly medications

would be just as good so that they could feel comfortable prescribing them. This would save the state money and allow it to help more poor people gain access to care. It was a cost benefit comparison among the various drugs. As we see with the TMCs, knowledge is the key to safely buying medication while saving money; here too, knowledge is crucial for saving money by getting the most effective medication for the lowest price. Advertising by the drug companies was thought to create the high demand for certain medications without regard to the fact that many of the newer drugs did not outperform the older, cheaper ones. Frank Baumeister, M.D. and member of the Oregon Health Resources Commission explains how advertising can affect a doctor's prescription behavior,

It's been shown that about 30 percent of physicians will provide the drug. It's easier to write a prescription than to give a long dissertation and explanation to try to dissuade a patient when your waiting room is full and you've got a patient in the next examining room that's been waiting, particularly if you don't think it's going to make that much difference. And the physicians get their education in that way [from the drug company ads], and that education is not objective. It's very biased. But in a way, the physicians are at the mercy of the drug salesmen (Ibid.).

The Oregon's Consumer Reports Bill would come in and provide doctors with an unbiased source of information about the medications to help them make better decisions about what to prescribe to their patients. Governor Kitzhaber explains, "Imagine how difficult it would be for you, as a consumer, to buy a toaster or a car or an appliance without *Consumer Reports* that gives you objective information to compare those products. That doesn't exist in the drug market today. Really, all we're trying to do in Oregon is to create a *Consumer Reports* for prescription drugs" (Ibid.). From this information they would create a "preferred drug list" that would list the medications that

provided the biggest “bang for the buck.” The pharmaceutical companies did not appreciate this idea since it threatened their profit margins and they sent 26 lobbyists to Oregon to stop this bill (just as they tried to stop Maine from passing its own). Governor Kitzhaber describes what happened,

And they managed to keep the bill bottled up in committee and never had a public hearing, which is pretty remarkable in a state like Oregon that prides itself on public process. Well, I told them that if they didn't put the bill on the floor, I was going to veto the entire budget for the Department of Human Services, over a billion dollars, and call them back in two weeks to rebalance the budget, and then get on the state plane and go around the state explaining how the leadership was in the pocket of the multi-national drug companies. And miraculously, the bill showed up on the floor, actually, late on the last night of the session. It passed by a comfortable margin in both houses (Ibid.).

Once the bill went into effect they used well documented studies of various classes of drugs and determined if they were all equally effective, and if so, they then compared their prices. Those with the highest effectiveness and lowest prices went on the preferred drug list that was distributed to the doctors. Doctors have the option to ignore the preferred list and prescribe one of the more costly medications if they want to, and the pharmacy will fill it as ordered as long as the doctor writes DNS for “do not substitute.” The drug companies’ concern over the possible effect this bill would have on their market share turned out to be valid. Medications that were on the preferred drug list increased their market share while those not on the list decreased their market share (Ibid.).

Other states have considered purchasing their medications from Canada in order to save money. The pharmaceutical companies responded by limiting the amount of medication they would sell to Canada in an attempt to deter this practice (Ibid.). The TMCs perceive that the pharmaceutical companies control what they can buy in Mexico

through this practice as well. For instance, while I was conducting my participant observation I noticed a lot of snowbirds who were having difficulty finding a Belgium manufactured generic version of Lipitor that they had purchased the year before. Since so many of them had used it previously they trusted it, and would not easily accept a substitute that they had no experience with. Harry used to buy this generic medication, but this year the pharmacies on the main street say they don't have it. The generic costs him 20% less than the name brand so he feels that it is worth choosing it if he can find it. He explained, "Some of the main [pharmacies] have stopped carrying certain generics due to pressure from prescription drug companies in the U.S." The implication is that the pharmaceutical companies are restricting access by not allowing Mexico to purchase certain medications, which prevents the consumer from buying them at an affordable price. This strategy was most recently deterred by the U.S. government as well when a bi-partisan committee proposal within the new healthcare reform bill that would have made drug importation from Canada and Western Europe easier was defeated (Hook and Levey 2009). For the TMCs, this is an example of the control of medication access by pharmaceutical companies to protect their profit at the expense of patients in need of those resources (see chapter 3 and 4). This also reflects the greater control that the core has over medical supplies and deciding who can access what items. Using a world systems perspective it is evident that as the periphery attempts to raise access for marginalized consumers, the core responds by limiting the amount of goods it provides or sells to them which they believe will in turn push the TMCs back to the U.S. system where the drug is available, thus ensuring that the consumer will pay the higher price for

it and raise the profit for the drug company; however, this misses the issue of their inability to pay that price for the medication which is why they were attempting to obtain it in the lower cost market in Mexico.

The drug companies' responses to these various State attempts at reducing the cost of medications indicate their commitment to protecting their profit. It does not endear them to the consumers since they are perceived as blocking people's access to a health resource so that they can make billions of dollars of profit each year. The response of the pharmaceutical companies is that without making the profits that they make, research and development (R and D) of new drugs would slow down or even stop. In their defense, the drug companies argue that the creation of new medications is a long and arduous process involving a lot of "misses" before the correct compound is found. Sidney Taurel, CEO of Eli Lilly and Company stated that it takes 12-15 years from drug conception to marketable product. Once they have an idea, they go through "tens of thousands of compounds" to find the one that seems to work. This step often takes between 5 and 10 years to complete. The next step is then to test it on animals to see if it has toxic side effects, if it does, then they have to go back to step one, if not then they can move onto the three phases of clinical trials with human subjects. Only 1 in 50 make it to the human clinical trials, which is the most expensive stage in the development process, and only 20% of those will "make it to market" (Ibid.). Uwe Reinhardt, a U.S. health policy commentator of Princeton University, elucidates "The total cost per successful drug-- it's certainly somewhere in the hundreds of millions" (Ibid.). Furthermore, according to Sidney Taurel only 30% of those that are sold will recover their R and D

costs for the company. Thus, they need to cover not only their production and research costs, but those of the ones that didn't make it as well. Therefore, if price controls were enacted to drive down the cost of medications, then companies would be forced to cut down on R and D and thus, innovation in drug therapies would dry up and people would not be able to have the drugs they need in the future. So cures for cancer, AIDS and other devastating diseases would not be developed and more people would suffer, because companies are not going to invest all of this time and money if they are not going to get a good profit from it. Taurel explains, "So it's a very, very, very risky business. And as a result, investors expect high returns to compensate for the high risks of this business" (Ibid.). I suspect that these "high returns" to investors is really what drives up the prices of the medications. This raises the question of whether people would be willing to invest money in medications, treatments, and cures if the only "return" was the knowledge that people would have these life altering resources.

The issue is framed as innovative research for new drugs vs. accessibility of medications for sick people. Marcia Angell, a Harvard Medical School doctor, and former editor of The New England Journal of Medicine and author of the book The Truth About the Drug Companies: How They Deceive Us and What to do About It (2004/2005), argues that the pharmaceutical companies make this case for high profits to fund R & D "...as though they were just eking out, just barely managing to survive" (PBS Frontline 2003). However, she points out that

The pharmaceutical industry is stunningly, staggeringly profitable. The 10 drug companies on the *Fortune 500* list last year took in net profits of 18.5 percent on sales. That's 18.5 percent. That is stunning. The median for the

other industries on the *Fortune 500* list was a little over 3 percent, 3.3 percent of sales. And this has been the case for the last 20 years (Ibid.).

These drug companies are billion dollar corporations. For instance, Eli Lilly headquartered in Indianapolis and who produces the medications Prozac and Zyprexa, is a \$70 billion business with 41,000 employees globally. “In 2002, they sold over \$11 billion worth of drugs” (Ibid.). Additionally, Merck based in New Jersey earned \$1.5 billion for Singulair and \$2.5 billion for Vioxx in 2002 (Ibid.). Maine’s Senator Chellie Pingree (1992-2000) expounds,

We're all completely committed to major advances in medicine and in prescription drugs, but this is the health care system. And you're not talking about a computer chip or a Rolls Royce or some product which, you know, maybe you have the right to make all the profits you want in the world. This is something that keeps people alive (Ibid.).

Additionally, most of the new medications that they are touting as part of this innovation that would dry up with price controls are for drugs that are “copy cats” – they are similar to drugs already created, tested and on the market (Ibid.). With a new formula, such as combining it with another medication, or making it time released, or some other minor adjustment, it receives a new patent and new advertising so the profits keep rolling in on a medication that has already recouped it’s production costs. Marcia Angell, M.D. maintains, “It's a threat. It's a threat to the American public. They are saying, ‘Don't mess with us. Do nothing about our obscene profits. Do nothing about these unsustainable increases in prices, or else we will not give you your miracle cures.’ Well, guess what? They're not giving you the miracle cures in the first place” (Ibid.).

While this economic argument may make sense with other products, it seems a bit disingenuous when talking about medication, a life sustaining and comforting resource.

It is clear that the role of the pharmaceutical companies is fraught with ambiguity. They are providing a health resource – medicine – but also restricting access to it based on one's ability to pay for it due to their desire to make a profit on it. It seems rather insidious, almost like blackmail, as people are enculturated into the belief that one should put his/her health above all else. After all, what is your health worth? Most people would pay whatever they could, forsaking luxuries as well as necessities, to access health resources as these impact one's life. My work with the TMCs shows that they are employing strategies such as cutting medications in half, taking them every other day instead of every day, or seeing which ones they can do without when they can no longer afford them (chapter 3). People will do whatever is necessary to obtain health resources that they believe will make a difference in their life.

The strategies of Maine and Oregon, along with others, signaled that the pharmaceutical market had hit a price peak and was about to shift to lower prices to make medications more affordable for everyone. The patients/consumers were no longer willing or able to pay the prices set by the drug companies and they were pushing back with the help of the states. Facing profit loss from cross-border and state control strategies, they changed their lobbying position with Congress. Initially they fought any drug coverage for Medicare, now they supported the Republican version of a Medicare prescription bill that would provide coverage with the least impact on their revenue. In fact, some would argue that it would increase their revenue by increasing their market to include previously uninsured seniors.

There were two bills being considered, the first, supported by Democrats, would have the government purchase the medications on behalf of the seniors on Medicare. This approach was not supported by the pharmaceutical companies because with Medicaid drug purchases already made by the government it would give the administration approximately a 52% share of the medicine market. Having a majority of the market would allow them to effectively set the price for medications. The second bill, supported by Republicans, gave the buying power to individual HMO programs that would negotiate their own pricing with the companies. Dividing the medication purchasing would result in each HMO having a much smaller market share; thus curtailing their power to negotiate lower prices in comparison to the government's power if the other bill passed. Therefore, not surprisingly the drug companies supported the second bill. And since they make considerable campaign contributions to many congress people (both Democrats and Republicans), it should come as no surprise that with a Republican congress majority and a Republican president, the second bill was the one that eventually ended up being the law. This shows that these companies can, and do, respond to market forces when people and larger entities like states, push back. Maybe this is the answer to this difficult problem, is that more people who are the consumers of these medications need to take a stand against the unaffordability of them. The fact that they purchase these resources outside of the United States relieves the pressure on the pharmaceutical companies to actually change their pricing system, which allows them to charge their highest prices in the United States without a consequence. Their high profits also translates into high power since they can afford the lobbyists, the high campaign

contributions to congress people and the expensive marketing promotions to doctors and patients that keep them making these elevated profits. The Medicare prescription bill is evidence that they can change, we just need to find the correct motivation (which appears to be money) to push it along.

As to the argument that lowering medication prices would harm future treatment options, it is important to point out that there are other ways to fund R and D if that is the problem. Perhaps there is another way to deal with this issue that would allow new research and increase affordability. I don't think we are necessarily locked into this system, there are ways we could change it. However, these companies make these statements as though there are no other options that could be chosen, such as cutting other aspects of expenses such as marketing (which would also reduce their profits, so they are not inclined to do this). Additionally, this might be one area where U.S. citizens would support spending their tax dollars to reduce the final cost of the medication through funding research for new drugs. If the high cost of medicine is due to R & D, then we have to find a new way that will allow the pursuit of new treatments while providing the most access for those who will benefit from this new technology.

Future research

My research provides much needed insight into the strategies that transnational medical consumers (TMCs) use to subsidize their U.S. care access. It demonstrates the need for better access to medications, eye glasses and dental work for seniors, poor, uninsured and underinsured people in the United States. It is a good foundation, but much more work in this area remains to be done. The processes of transnational

healthcare at the US-Mexican border encompass several political and economic factors making this a complex issue that requires further investigation.

Since I conducted my research much has changed and much has stayed the same. Healthcare is still not available for millions of U.S. residents and many remain underinsured. However, Medicare has taken a step toward fixing the inadequate prescription coverage by adding a new prescription medicine benefit that is operated through various HMOs. This was touted as a way to help seniors access their medications without having to go to Mexico or Canada for more affordable pricing. However, anecdotally I am hearing that it is not solving the problem as well as seniors had hoped. Each insurance provider decides which medications it will carry and then negotiates its prices with the pharmaceutical companies for those who subscribe to their plans. Their ability to obtain lower prices depends on the number of clients they have, those with more clients can bargain for lower prices than those with fewer clients since they will presumably buy more. Additionally, each insurance provider decides which medications to include in their formulary (those that are available for their clients) which results in different medications covered for different providers. Seniors then have to compare plans to see which one will best meet their medication needs. It often comes down to which one will cover the most number of medications, or the majority of their medication costs so that they can best manage their pharmaceutical needs within their budget. Either way, many still have to pay for some of their medication out-of-pocket. Future research in this area needs to examine the impact of the new prescription drug plan to see if these problems are being addressed, and if TMC seniors have changed their

Mexican medication and service access as a result of these legislative changes.

Additionally, the latest healthcare bill may also have impacts on this practice for the uninsured and underinsured seniors and non-seniors alike that will need to be investigated as they unfold.

Another legislative change that has occurred since then is the institution of the passport requirement to re-enter the United States from Mexico. It would be interesting to examine whether or not this has impacted cross-border healthcare due to potential difficulties of obtaining a passport (such as cost and wait time). Additionally, the possible impact on the time it takes to cross back into the United States due to checking passports may deter TMCs as it could take up to 1½ hours to cross back into the United States during the winter season without them. Therefore, this could just represent another institutional barrier to accessing care in Mexico for at-risk populations that are attempting to meet their health needs outside of the U.S. system. On the contrary, this new requirement could possibly make crossing back into the United States easier by streamlining the process. The perceptions of the TMCs to this new rule along with the changes to Medicare access may influence whether or not they bother to get a passport or decide to forgo Mexican medicine and services altogether.

Furthermore, a comparison between the U.S.-Mexican Border and the U.S.-Canadian Border is necessary to determine the similarities and differences between the processes and practices of TMCs in both areas. An assessment of the products and services obtained, how, why, when, and by whom in each border region will help us to understand which are unique to the U.S.-Mexican Border area and which are common to

both borders. The perceptions of safety and risk along with the warnings, if any, at the U.S.-Canadian Border can contribute to our comprehension of the roles that potential hazards play at both borders, along with the relationship that these have with perceptions of each respective nation. How insurers, legislatures, the FDA and DHHS and media work within the northern border can provide insight into the institutional responses to cross-border access in Canada as opposed to Mexico. Examining whether or not the TMCs accessing care in Mexico are also accessing care in Canada may offer important further details on how this strategy impacts their lives economically, physically, emotionally, year-round.

Policy Implications

Transnational healthcare processes shape, and are shaped by, local and global political economic structures of both nations, as well as, the U.S.-Mexican Border itself. The implications of this practice for medical markets, patient health, insurance coverage, and border town economies are enormous. This study provides valuable qualitative documentation and understanding of the cross-border strategy and how this response to healthcare access disparities in the United States works to alleviate the health concerns for a variety of at-risk populations, such as the elderly, low income, and uninsured and underinsured people. This research has practical implications that can improve public health and insurance services for populations living in this region through innovations in international cooperation projects on health, the facilitation of healthcare access for at risk populations, and increased economic opportunities in healthcare in both nations. The opportunity to help the people who are excluded from the U.S. medical system using

border resources is already evident through the practices of the TMCs. Policy makers and insurance providers can use this information to help improve coverage and service access in the United States to either eliminate the need for people to cross the border into Mexico to obtain healthcare or to improve services and access of Mexican facilities. While the issues surrounding this practice are complex and multifaceted, one option may be to expand the border insurance policies to include non-border and temporary border residents in their coverage populations. This would allow those seeking dental care, eye glasses and medication in Mexico easier access to these resources, and perhaps even increasing the numbers of those able to benefit from this option. Using Mexican facilities may be a way to provide lower cost, quality care for U.S. residents and this may be a new area of global/transnational medical markets that would benefit U.S. populations and businesses, as well as, Mexican medical providers. Transnational partnerships between providers in both countries could be an innovative way for the United States to meet the needs of its underserved populations. This could help provide the framework for bi-national strategies and programs that most researchers agree are needed to alleviate the health disparities found in the border region. It is important to note that this solution is limited at best, since the issues of access within the United States are not addressed by it; however, it may relieve the urgency for those in need now as they wait for a more comprehensive resolution to healthcare acquisition. Studies as this one will help policy makers identify areas that could be regulated and improved to assure quality care is received when people cross the border for care.

Changing the U.S. System

In the United States we have an excellent medical system as far as treatments and technology; unfortunately, we fail in providing adequate access to these health assets. People often state that this is how the system works, this is how we move ahead in treatments and technology and it is the price we pay due to our system. But this makes it sound as though we are victims of our system, as though we don't create it, shape it, perpetuate it or change it; as though we do not have any control over it, when in fact, we (or at least some of us) are the masters of the system. As seen in chapters 3 and 4, the transnational social networks that are created and maintained by TMCs are a response to their exclusion from the U.S. system. It results in the creation of a binational medical system that transcends the border to encompass two medical systems with two sets of ideologies and laws/rules that they navigate in their pursuit of healthcare. Mexico as socialized medicine country with health as a guaranteed right in the constitution, and the U.S. with a fee for service system based on profit are embedded within the larger cultural ideologies, practices and structures. Thus, medical structures are culturally constructed to reflect the ideologies and social structures of their respective contexts and as such can change if the culture changes. We can at any time decide that our system is not what we want and try something else. Granted we do not all have equal power to change the system if it does not work for us, but those telling us that this is how it works, often do have the power to change it if they wanted to; but as stakeholders who are able to work the system to their benefit and profit, they do not see a reason to change it. Change for them means uncertainty that they would enjoy the same benefits that they now have and

since they have the power to keep the status quo, while maintaining that it is not up to them (so that they do not carry the blame), they stop change in its tracks – they make change unviable, unachievable, unbelievable.

The hegemonic myth of equal opportunity is presented, laying the blame for the lack of access squarely on the individual who is not working hard enough to meet his/her needs. It is presented as though everyone has equal access to the system. If you are not lazy and work hard, you should be able to access the care you want. The system is never seen as the problem. In fact, the issues with the system are seen as necessary evils which cannot be remedied without the collapse of the whole system. So, the rhetoric goes, “it may be a flawed system, but it is the best one we have, and if we change it, it would be worse.” Another argument is that if the United States adds a nationalized option to its medical insurance choices our nation would no longer be capitalist, but instead, would become socialist. This argument draws on cold war and “red scare” ideologies where socialism and communism is framed as unpatriotic, un-American, and to be avoided at all costs. Interestingly, the United States collectively supports the police force, military, firefighters, school teachers and other government employees without considering itself socialist. This speaks to the hegemonic power of the political and medical institutions in the United States to sway not only popular opinion, but political action as well. It is no secret that those with money have considerably more political power than those without. The political power that was wielded by pharmaceutical companies against state governments is an example of how wealth is used to protect the current medical system. One way to combat that power is with the power of numbers, which is difficult to obtain

when the current hegemony divides people and tells them that they are not responsible for other people's suffering. The 'culture of fear' that Michael Moore addresses in his documentary *Bowling for Columbine* (2002) is another rhetorical tool used by power holders – the fear of change, the fear of the unknown, the fear of higher taxes, the fear of government bureaucracies, the fear that innovation would be lost, the fear of Mexico as corrupt, scary, lawless, foreign and unknown and so on are also used to control and constrain medical access and structures. Additionally, the U.S. FDA and DHHS use the fear of substandard and/or counterfeit drugs and care in their warnings to scare TMCs away from Mexican medications and services. The one fear that they do not have at their disposal that trumps all of these is the fear of disease, debilitation, pain and death. That fear is stronger, because after all, if you are facing death, what have you got to lose? What are you risking that isn't already at risk if you do nothing? This fear motivates people to push aside all other fears in an attempt to stave off death and disease for a while longer.

Moreover, the arguments that innovation would cease if the profit margins for medications and technologies were to decrease seems to suggest that the only reason anyone is in the business of searching for cures, treatments and preventatives such as vaccines is for the money. I would argue that there are people who would do this work for other reasons, such as a belief in public good, the motivation of glory for the discovery, and the motivation of scientific inquiry for the sake of finding the answers to unanswered questions. It may mean a different set up for this work to take place, it may take longer than it does now, or it may not; but to not act due to the fear that change

might not work is not a scientific mindset. In science, we conduct experiments to see what will happen. We come up with hypotheses based on what we currently know and then test them. Changing our system so that more people can benefit from it is an experiment that will require some trial and error, but we have data from other countries that can show us what works and what doesn't, to help us make better decisions and to help us be more successful in our attempt to make this change work. Additionally, if it doesn't quite work in our first attempt, we are free to make further changes to improve it. We will not be stuck with another broken system, unless we choose to be.

Would people really fare worse with government supported healthcare access? It seems to work in other countries. Most countries with socialized medicine options have higher life expectancies and lower infant mortality and morbidity than we have here in the United States (table 6.1). These health indicators are often used as markers of a nation's over-all health. We pay more for our healthcare than any other nation, yet we are not number one in health status (Sapolsky 2005; OECD; Commonwealth Fund 2010). Robert Sapolsky explains, "Of Westernized nations, America has the greatest income inequality (40 percent of the wealth is controlled by 1 percent of the population) and the greatest discrepancy between expenditures on health care (number one in the world) and life expectancy (as of 2003, number 29)" (2005:85). According to health statistics collected by the Organization for Economic and Co-operative Development (OECD), the United States paid \$7,285 per capita in 2007 for healthcare compared to \$2,990 in the United Kingdom, and \$3,867 in Canada. The life expectancy in each country for that same year was 77.9 in the United States, 79.7 in the United Kingdom and 80.7 in Canada

(OECD). These numbers indicate that we are not getting what we are paying for and that our system is not working as well as it could. In fact,

Despite having the most expensive health care system, the United States ranks last overall compared to six other industrialized countries – Australia, Canada, Germany, the Netherlands, New Zealand, and the United Kingdom - on measures of health system performance in five areas: quality, efficiency, access to care, equity and the ability to lead long, healthy productive lives, according to a new Commonwealth Fund report (2010).

Table 6.1: Health Outcomes and Expenditures

| Country | Life Expectancy* | Infant Mortality** | Expenditures per capita |
|----------------|------------------|--------------------|-------------------------|
| Canada | 80.1 | 5.0 | \$3690.00 |
| France | 80.3 | 3.8 | \$3425.00 |
| Germany | 79.4 | 3.8 | \$3471.00 |
| Japan | 82.0 | 2.6 | \$2580.00 |
| Norway | 80.1 | 3.2 | \$4501.00 |
| Sweden | 80.6 | 2.8 | \$3113.00 |
| United Kingdom | 79.1 | 5.0 | \$2884.00 |
| United States | 77.4 | 6.7 | \$6931.00 |

Source: OECD, numbers given are for 2006, US dollars.

*total population at birth

**per 1,000 live births

Based on these numbers it appears that the U.S. system could be much more economically efficient and increase its population’s health outcomes while spending significantly less money. However, a hegemonic shift toward viewing health as a basic aspect of humanity that should be ensured by society and away from viewing it as a mechanism for profit needs to occur in order for this type of system to be feasible in the United States. The notion that we collectively are responsible for our society’s health and that we all benefit from a healthier civilization could help open the possibility for such a system to develop. Furthermore, unbiased, empirical data about national medicine programs is needed to shed light on how to use these systems to end the inadequacies in

the U.S. system without ending the innovation we all benefit from. One thing is certain; we cannot continue to ignore the health concerns that are growing out of poverty, greed and exclusion, for at some point these concerns will expand to become the next global pandemic. Our country is built on the ideas of innovation and experimentation, freedom and equality; we must honor those ideologies and work toward social justice for those who need it. We lose our humanity, if we put profit ahead of people, if we place ourselves as the victims of the system we created and we control. It is in our hands to make this work and the blame is ours if we do not.

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