Re-Building a Complex Partnership:

The Outlook for U.S.-Mexico Relations under the Biden Administration

Wilson Center
MEXICO INSTITUTE

January 2021

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Time to Relaunch the U.S.-Mexico Health Agenda

Key Policy Recommendations

The public health crisis has revealed common weaknesses and the need for a shared health agenda to enable our countries to work towards a common goal: better health.

- Improve collaboration and create a more effective binational health agenda that can help Mexico and the United States achieve SDG3 targets.
- Increase capacity to detect and assess outbreaks and other emergency health hazards.
- Strengthen emergency response capacities and establish a framework for trilateral collaboration to guide mutual assistance capabilities and ensure a quick and coordinated response to outbreaks of animal influenza or an influenza pandemic.
- Relaunch and update NAPAPI and expand objectives to include continued and enhanced cooperation on pandemic preparedness and response and bioterrorism threats.
- As U.S. migration policy changes under a Biden administration, adapt health policy for migrant populations accordingly.
- Reinvigorate the Border Health Commission, reconvene the Binational Technical Workgroup, and update the Healthy Border plan for a new target year.
- Establish more flexible insurance coverage for patients in either country for travel to the other.
- Replicate initiatives like Cancer Moonshot and Operation Warp Speed on a bilateral basis with a focus on the NCDs most prevalent in both countries.
- The FDA and COFEPRIS should share trial protocol review best practices and data packages; COFEPRIS should consider accepting FDA trial approvals.
- Increase focus on joint research efforts supported by both governments.
- Establish a collaborative approach to nursing education, including establishing academic exchanges between U.S. and Mexican schools of nursing and conformity of credentialing criteria to allow for a more flexible response to demand on either side of the border.

Despite the considerable differences with respect to the health of our nations and the structure and capacities of our health systems, the COVID-19 pandemic has brought us closer together. Mexico and the United States have been ranked among the countries with the worst response against the pandemic. The public health crisis has revealed common weaknesses and the need for a shared health agenda to enable our countries to work towards a shared goal: better health.

In the past 70 years, both countries have made significant progress in improving health conditions. The average American born in 1960 was expected to live until the age of 75 and the average Mexican until age 57. By 2010, life expectancy at birth, the most comprehensive measure of overall population health, had increased to 78.5 and 70 years respectively (see Table 1). This reflects sustained improved living standards and better access to quality medical care. For decades, health had been the great equalizer, across age groups, races, regions, and nations. More recently, however, this shared success story has gone awry. At least for the past decade, the United States and Mexico began to see a rapid deterioration of health conditions. U.S. life expectancy has been falling since 2014 and 14 of the 32 Mexican states have followed the same path since 2010; a major setback unseen in developed and developing countries during peace time in the last century. The COVID-19 pandemic has accelerated the trend.

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For many decades, the United States has been the world's largest health spender by all measures - total, per capita, and as a share of GDP (see Table 2). Nevertheless, health outcomes have fallen short compared to countries with less expensive health systems such as Japan, Australia, and most of continental Europe. In the Americas, Canada, Chile, Costa Rica, and Cuba have better performing health systems when measured by health outcomes. In their influential work, professors Anne Case and Angus Deaton describe the troubling finding of a marked and sustained increase in midlife mortality among white non-Hispanic Americans, especially among the least educated.[1] The unexpectedly high levels of mortality reflect the overall deterioration in socioeconomic conditions leading to mental health problems, addiction – in part best depicted as the opioid crisis – and cardiovascular disease and diabetes fueled by the obesity pandemic that has hit both countries equally hard.

The Mexican experience is very similar. Decades of improvement in infant mortality rates are now being offset by increased premature mortality in young adults, mostly due to violence and the high prevalence of diabetes and cardiovascular disease. In the past two decades, the national homicide rate more than doubled, from 11 per 100,000 in 2000 to 22.9 in 2010 and reached 29.0 per 100,000 in 2019. States like Colima, Tamaulipas, and Guanajuato have seen a reduction in life expectancy for males of three to five years from the peak level achieved around 2006. In addition, almost three quarters (72.5%) of the adult population is overweight or obese, second only to the United States among OECD countries. Obesity is the leading public health concern in Mexico and an important risk factor for various chronic conditions.[2] Not surprisingly, diabetes rates increased from 7 to 12 percent of the adult population between 2000 and 2018. Mexico now has the OECD's highest rate of diabetes. Were trends to persist, the generation born in the next decade would expect to live fewer years than its parents, reversing gains made over the last eight decades.

COVID-19 has exacerbated the damage to health conditions and revealed the weaknesses of the Mexican and U.S. health systems. The full impact will become apparent over many years, but an interim assessment will be possible by year's end as reliable statistics on excess mortality become available. Mexico and the United States stand out among the world´s worst performers with avoidable deaths in the

hundreds of thousands when compared to average world mortality trends. A health crisis of this magnitude will oblige a deep evaluation followed by major policy reforms and an institutional strengthening agenda.

Economic integration has intertwined the health of our populations. Viruses and airborne diseases do not respect physical borders. With a shared border of nearly two-thousand-miles, more than 350 million documented crossings per year, and two-way trade in goods worth more than USD$620 billion a year, revitalizing the dormant bilateral health agenda is both a social and economic imperative. Preventable health problems can best be tackled by acting directly on the underlying cause or risk factors which at times may originate outside one's border (e.g., migrant and border health or pandemic threats). Further, shared quality standards, achieved through policy harmonization and bilateral cooperation, will permit comparative measurement of outcomes. This is particularly important for medical tourism, safety and efficacy standards for pharmaceuticals and devices, and labor market integration for medical and nursing professionals. Finally, economic integration has been coupled with behavioral and lifestyle convergence, with sometimes unexpected consequences on health. As such, much can be achieved through early identification and combined tackling of risky practices including eating and drinking habits, physical activity levels, mental health, and addiction.

The rest of this chapter presents the way forward across some of the most important opportunities for enhanced bilateral health collaboration. It is not meant to be a new or exhaustive list of potentially valuable areas for collaboration. Rather, it should be seen as an initial roadmap for reengagement to build trust based on early rewards and gain momentum for longer-term efforts to deliver lasting health gains.

Regional Health and the 2030 Agenda

Sustainable Development Goal 3 (SDG3) of the United Nations 2030 Agenda, adopted unanimously by the UN General Assembly in 2015, reads, "*Ensure healthy lives and promote wellbeing for all at all ages*." SDG3 contains a heterogeneous set of 13 targets. While some are quantitative in nature and more relevant to poor countries and communities (and no longer binding for the United States and Mexico at the national level), others focus on Non-Communicable Diseases (NCDs) and pose more of a challenge since neither Mexico nor the United States is on track to achieve them. Some are qualitative and aspirational and will require considerable upscaling of efforts to make noticeable progress. A more effective binational health agenda can help Mexico and the United States achieve these targets in three ways: i) directly by tackling cross-border health issues; ii) indirectly through example and best practice sharing; and iii) through coordinated assistance to regional countries.

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At least five of the SDG3's most challenging targets are directly amenable to a more effective binational collaboration. U.S. and Mexican agencies can devise joint strategies to prevent and treat substance abuse, including narcotic drug abuse and harmful use of alcohol (SDG 3.5). The number of deaths and illnesses from hazardous chemicals and air, water, and soil pollution and contamination (SDG 3.9) can be substantially reduced through focused interventions in the border region where more than 15 million people live (see Section 4).[3] Coordinated efforts can be directed to promote implementation of the WHO Framework Convention on Tobacco Control (SDG 3a). As will be discussed in the following sections, health financing can be increased, especially in Mexico, to improve recruitment, development, and training to help retain and grow the health workforce (SDG 3c). Finally, COVID-19 has made evident the need to increase capacity for early warning, risk reduction, and management of national and global health risks (SDG 3d – see next section).

No less important is the need for enhanced experience sharing and mutual learning. Given the similar health profiles in terms of causes of mortality and risk factors (see Table 2), technical collaboration can help identify and implement cost-effective interventions to achieve a one-third reduction in premature mortality caused by NCDs (SDG 3.4) and halve the number of deaths and injuries from road traffic accidents (SDG 3.6). Complementing these efforts looms the challenging, and elusive, target for both countries of universal health coverage, including financial risk protection and access to quality essential health-care services (SDG 3.8).

Coordinated regional overseas development assistance can be aimed at helping the poor Caribbean, Central, and South American countries. Although no longer a pressing health issue for Mexico and the United States, maternal mortality (SDG 3.1), preventable deaths of newborns and children under five, and neonatal mortality (SDG 3.2) remain unacceptably high, especially in less privileged population groups. Further, HIV/AIDS, tuberculosis, malaria, and neglected tropical diseases remain endemic in many parts of the Americas, as are hepatitis, water-borne diseases, and other communicable diseases (SDG 3.3). Both countries, in collaboration with PAHO, can support efforts to ensure universal access to sexual and reproductive healthcare services, including for family planning, information and education, and the integration of reproductive health into national strategies and programs (SDG 3.7). Finally, with the help of CSOs and research foundations, the research and development of vaccines and medicines and access to affordable medicines for the communicable and non-communicable diseases that primarily affect Latin American developing countries (SDG 3b) can be emphasized and supported.

Health Security and Emergency Response

North America is under constant health threats from disease outbreaks and natural disasters. Mexico and the United States are among the hardest hit by the new severe acute respiratory syndrome virus (SARS CoV 2 also known as COVID-19), the first major emerging infectious disease of the 21st century. Just in the past 15 years, health emergency responses have been triggered by several international outbreaks: the Middle East respiratory syndrome (MERS) in 2005, the first SARS outbreak in 2006, the H1N1 Swine Flu of 2009 that originated in Mexico, and Ebola in 2018. In addition, the United States and Mexico regularly face significant numbers of new variants of human cases of influenza, outbreaks of mosquito-borne diseases, such as Zika and dengue, food-borne diseases, and most recently, the resurgence of measles.[4] Greater demand for animal protein driven by population and economic growth, combined with the unpredictable effects on weather patterns caused by climate change, are likely to increase the frequency of vector borne disease outbreaks.

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Health emergency programs have been an integral part of the bilateral health agenda which has consistently highlighted the need for increased capacity to detect and assess outbreaks and other emergency health hazards. The G7 countries invited Mexico in 2002 to join the Global Health Security Initiative. In 2010, the United States launched and chaired the North American Health Security Working Group partly in response to the first SARS outbreak. And in April 2012, the North American Plan for Animal and Pandemic Influenza (NAPAPI)[5] was launched by Presidents Obama and Calderón and Prime Minister Harper in response to the 2009 H1N1 pandemic. NAPAPI is perhaps the most comprehensive, regional, and cross-sectoral health security framework. It outlines how the three countries should strengthen emergency response capacities and establishes a framework for trilateral collaboration to guide mutual assistance capabilities and ensure a quick and coordinated response to outbreaks of animal influenza or an influenza

pandemic.[6] The key areas identified for joint action are:

- Mutual assistance during a response, particularly with regard to sharing medical countermeasures and personnel;
- Interconnected systems for surveillance and early warning;
- Protocols for emergency communications, laboratory sample transportation, and joint epidemiological investigations;
- Integration on human and animal health; and
- Development of border policies and protection of critical infrastructure.

NAPAPI is in need of a relaunch in face of COVID-19. The next North American Leaders' Summit (NALS) could be the appropriate forum to renew political commitments around health security by the Presidents of Mexico and the United States and the Prime Minister of Canada.[7] The NAPAPI objectives should be expanded beyond influenza to include continued and enhanced cooperation on pandemic preparedness and response and bioterrorism threats. Based on the lessons learned from COVID-19, creation of an updated framework to improve preparedness including deeper technical cooperation among public health institutions and agencies, enhanced mechanisms for timely data sharing, and improved and reliable epidemiological surveillance of potential health threats will be essential to maintain political commitment and technical momentum when, as has been the case before, support wanes in-between pandemic periods. In addition, further analysis is necessary to better understand the impact on cross-border medical supply chains stemming from invocation of the Defense Production Act in response to public health emergencies.

Migrant Health and Portable Health Coverage

Migration has been an intrinsic part of the binational history and experience since the 19th century. Indeed, more than 37 million American citizens of Mexican descent and an estimated 11 million documented and undocumented Mexicans live or reside in the United States. Further, it is estimated that more than one million American citizens live permanently in Mexico, mostly expatriates and retirees. Not surprisingly the Mexico–U.S. border is considered the busiest border in the world with approximately 350 million documented crossings annually.

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Delivering health coverage to migrant populations is a complex task. Part of the challenge relates to the nature and drivers of migration. Adverse events explain forced migration. These include economic hardship, violence, and the need to seek better living conditions elsewhere. The most common health needs of forced migrants, who tend to be poor, young, and predominantly male, are for emergency care for injuries and other occupational health hazards and addiction. Financial barriers and weak institutional support mechanisms are a major obstacle to quality care. In contrast, voluntary migration is mostly driven by the job market or educational opportunities derived from decades of economic integration, or by families seeking a more sustainable livelihood, including retired Americans pursuing a better climate, cultural preferences, or affordable long-term care. Access to quality care is still limited as public health coverage – IMSS or Medicare – is not portable across the border and migrants must rely on private insurance or pay out of pocket. The second part of the challenge, shared by all groups, relates to changing health needs of migrants and the difficulty of delivering patient-centered, integrated care across the migration cycle – origin, transit, arrival, return. Responding to this challenge is an important component of the binational health agenda for both the private and public sectors.

Traditionally, the most important health support mechanism for undocumented migrants of Mexican and Central American origin has been the Binational Health Week (BHW).[8] Over the past 20 years, the BHW has evolved into a well-organized platform to coordinate and mobilize health support efforts focused on the poor Latino population that lives in the United States and Canada. Each October, federal, state, and local government agencies, community-based organizations, and volunteers come together to deliver health promotion, prevention, and low complexity medical care. Events are coordinated by Latin American consulates and government agencies including the Ministries of Health and Foreign Affairs of Mexico. Key players include Civil Service Organizations such as the Health Initiative of the Americas, a program of the University of California, Berkeley, School of Public Health.

Aside from the BHW, little progress has been made over the years. IMSS has tried, through Mexican consulates, to encourage affiliation by migrant workers in the United States to provide medical coverage for family members left behind with mixed results. With respect to medical coverage for voluntary migrants, private health providers in Mexico – mostly quality accredited hospitals – have reached agreements with U.S.-based insurance companies to obtain reimbursement for care delivered to tourists and retirees. Sadly, and contrary to what has been the experience in European countries, no progress has been made with public insurance schemes for cross-border coverage.

The transition from a Trump to a Biden administration will surely result in changes to U.S. migration policy. The health policy for migrant populations will need to adapt accordingly. Most likely, a new human rights-based approach to migrant workers and their families will require more organized support and agency mobilization to reach a larger number of disadvantaged Latino migrants and provide them with more inclusive coverage schemes. Talks on cross-border coverage for Medicare and IMSS beneficiaries would be a major breakthrough that could deliver integrated care, drive higher standards of care for many Mexican providers, and generate savings for U.S. taxpayers.

Border Health

The health-related challenges of the U.S.-Mexico Border reflect the region's unique nature. Encompassing some of the wealthiest areas of Mexico and some of the poorest areas of the United States, the region is the epicenter of the economic, cultural, and social aspects of the bilateral relationship. Indeed, the interconnected nature of the region long pre-dates the current national border. The region also provides clear examples of how environment and commerce can impact health. Residents in both countries share water for drinking and irrigation as well as wastewater (sometimes inadvertently), and face threats from air pollution when idling trucks waiting to cross the border release carbon dioxide and other greenhouse gases which contribute to global warming and to high incidences of asthma in border communities. Air and water pollution issues are most acute in the highly populated areas of San Diego/Tijuana and Laredo/Nuevo Laredo but are widespread throughout the border region.

The United States-Mexico Border Health Commission was established in 2000 to "provide international leadership to improve health and quality of life along the U.S.-México border."[9] The Commission is charged with facilitating actions and viable, evidence-based solutions to eliminate health disparities and improve quality of life. In 2015, the Commission established the *Healthy Border 2020* initiative, based on the accomplishments of the *Healthy Border 2010: An Agenda for Improving Health on the United States-Mexico Border* initiative.

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The 2020 initiative identified five priorities of bilateral concern:

- Chronic and Degenerative Disease
- Infectious Diseases
- Maternal and Child Health
- Mental Health and Addiction
- Injury Prevention[10]

The most common causes and/or social determinants of these priority areas included “poverty, health education/access to information, and an unhealthy diet, followed in frequency by access and quality of medical care.” Each of the issues remain salient today; infectious disease and mental health and addiction were exacerbated by the COVID-19 pandemic. Both Mexican President López Obrador and U.S. President Biden have highlighted some of these issues in their public remarks and policy documents. Further, the broader societal factors identified in 2015 have changed little.

Regrettably, the Commission’s activities have seemingly diminished over the past few years and particularly during the COVID-19 pandemic. A final report on the Healthy Border 2020 initiative, scheduled for release in July 2020, has not yet been published. Indeed, some of the BHC webpages (on the U.S. side) have not been updated since December 2017.[11] To reinvigorate the BHC, the respective Secretaries of Health should reconvene the Binational Technical Workgroup which developed the Healthy Border 2020 plan and provide the Working Group with a mandate to update the plan for a new target year (perhaps 2030 to be consistent with the UN’s Sustainable Development Goals) and to update the webpages to reflect the latest activities and developments.

Medical Tourism

American and Mexican citizens have long crossed the border to seek medical care. Americans, especially those within easy driving distance of the border, generally travel south in pursuit of lower costs and more personalized care. As a result, Mexico is the second largest destination for medical tourism globally (number one for dentistry) with 1.4 – 3 million patients traveling to Mexico annually for treatment.[12] Surgical procedures in Mexico can cost 40 – 65 percent less than in the United States, and the Mexican government has long sought to capitalize on the much lower costs of procedures and of prescription drugs. Many Mexican surgeons have been trained in the United States or Europe, though Mexican hospitals tend to be smaller, reducing the number of procedures performed.

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During the 10th Medical Tourism conference in Cancun in 2019, Mexican Secretary of Tourism Miguel Torruco Marques attributed the sustained growth in medical tourism to factors including geography; private investment in hospitals, infrastructure, and high-tech equipment; quality of medical services; and the cost of treatment.[13] Indeed, Americans frequently travel to Mexico for elective surgeries such as cosmetic procedures or dental work not covered by insurance. Some companies, such as Ashley Furniture, however, take advantage of the substantial cost savings by offering medical tourism options through their employee health plan, including one option that provides treatment by U.S. surgeons who travel to Mexico to perform surgery in Mexican hospitals.[14]

Affluent Mexican citizens often travel to the United States for advanced treatment for serious illnesses like cancer. Major U.S. hospitals such as MD Anderson advertise in Mexico, while the world-famous Mayo Clinic maintains an office in Mexico City to help facilitate travel and schedule appointments at its U.S.-based facilities. There are also private-sector hospital partnerships such as Christus Muguerza, which operates a U.S.-style network in Mexico and accepts many U.S. insurance plans, and SIMNSA, a San Diego-based Health Maintenance Organization (HMO), which provides care in Mexico for beneficiaries living and working in the United States.[15] Given the size of our economies and the proximity, the number of these partnerships remains comparatively low.

Medical tourism provides an important source of revenue for Mexico, especially along the border. While 2020 activity is down as much as 75 percent, it will likely rebound once the COVID-19 pandemic subsides. In the United States, receiving hospitals and their communities benefit as well since foreign patients often pay higher fees than would be paid by Americans covered by public or private health insurance programs. It is likely that more flexible insurance coverage for patients in either country for travel to the other would increase cross-border medical tourism. Portability of U.S. public insurance (Medicare/Medicaid) could provide a useful release valve for patients unable to afford care in the United States, thus reducing demand in border-region hospitals, while allowing U.S. retirees in Mexico to use their coverage without needing to return home for care. Sending more critical care patients to the United States would improve access to care for those patients and allow the Mexican system to focus resources and attention on patients it is more able to treat.

Medical Research

Sharing of confidential information regarding the quality, safety, and efficacy of products between the United States and Mexico dates back to the 2002 FDA-COFEPRIS Confidentiality Commitment which permits the regulatory agencies to share non-public information.[16] The agencies have steadily strengthened their collaborative relationship, including through the 2009 establishment of an FDA office in Mexico City to, *inter alia,* support science-based regulatory decision-making and pursue the best possible public health solutions.[17] Most recently, in October 2020, the agencies signed a Statement of Intent to enhance their partnership on food safety.[18] Given the growth in the export of fruits and vegetables from Mexico to the United States since the 1994 entry into force of the North American Free Trade Agreement (NAFTA), collaboration to ensure food safety is essential.

Binational collaboration is not limited to exchanges of information or assigning public officials to an embassy nor to the public sector. Substantial private sector collaboration, especially through clinical trials, occurs as well. Clinical trials enhance access to new treatments for enrolled patients and provide educational opportunities for healthcare practitioners through exposure to the latest research and care techniques. Mexico offers several important advantages as a clinical trial location based on geographic proximity, technical capacity, demographics, and cost. Mexico's ongoing demographic transition is driving increases in non-communicable diseases (NCDs) such as cancers, diabetes, and heart disease – all of which are ripe for drug and device development. Further, the Mexican Social Security Institute (IMSS), one of the largest health providers in the Western Hemisphere, and other public institutions cover about 70 percent of the Mexican population, providing ample patient data for research under appropriate protocols. These features should appeal to U.S. drug and device manufacturers which often struggle to enroll adequate numbers of patients. Sadly, Mexico has yet to fully capitalize on its advantages. As a result, only about 1 percent of global clinical trial participants are from Mexico.[19]

COFEPRIS' comparatively slow approval timeline is often cited as an impediment to greater clinical trial activity in Mexico. Given the pressure to bring new drugs and treatments to market quickly, approval timelines are a significant factor in manufacturers' decision-making process regarding trial location. At roughly ten months, Mexico's approval timeline is one of the slowest in Latin America. Efforts to accelerate this timeline, while maintaining patient safety, have faltered.

Two U.S. Government-sponsored initiatives, the Cancer Moonshot and Operation Warp Speed (for COVID-19 vaccines), could be replicated on a bilateral basis with a focus on the NCDs most prevalent in both countries. As a start, FDA and COFEPRIS should share trial protocol review best practices and data packages under their information sharing agreements. COFEPRIS could consider accepting FDA trial approvals, subject to further review, as it does for drug and device authorizations. A focus on joint research efforts, supported by the government, would allow private firms and universities to combine Mexico's previously referenced advantages with U.S. public and private capital, research experience, and innovative capacity. Doing so would accelerate access to new treatment options during the trial process while enhanced competition within therapeutic areas would likely reduce prices for patients in both countries.

Education and Training

The World Health Organization (WHO) identifies a lack of adequate nursing coverage as one of the greatest impediments to health system efficiency. Both Mexico and the United States face nursing shortages. In Mexico, there are only 2.9 nurses/1,000 inhabitants (See Table 2).[20] More alarmingly, while the population has grown and aged, the overall number of nurses has been falling in recent years. In 2018, Mexico registered 864 fewer nurses and roughly 4,000 fewer in 2019.[21]

Though the rate of nurses per 1,000 citizens in the United States exceeds the OECD average, at 11.7 (see Table 2) nationally, nursing was the third-most in-demand job in the country in 2019. The American Association of Colleges of Nursing attributes the shortage to four factors:

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- Nursing school enrollment is not keeping pace with projected demand.
- Insufficient number of nursing school faculty members.
- High rate of retirement among existing nurses.
- Aging U.S. population driving demand.[22]

In addition, improvements in healthcare delivery, including increasing reliance on at-home or out-patient treatment (including telemedicine) means that in-hospital patients are generally sicker and more in need of skilled and specialized nursing care.[23] The same factors are likely to apply in Mexico, if not today, then in the future. Further, both countries face considerable disparity in the distribution of available nurses with urban areas generally better served.

The incoming Biden Administration has proposed to improve caregiving and health outcomes with particular focus on underserved communities by adding 150,000 community health workers (not all of whom would presumably be nurses). The Biden platform notes that "community health solutions can lead to better health outcomes, allow people to live with more independence, and ease caregiving challenges through a focus on prevention and care coordination, reducing unnecessary and expensive hospitalization."[24] Those comments would surely apply to Mexico, where President López Obrador committed to delivering universal healthcare to all Mexicans with an initial focus on the underserved during his 2018 campaign.

Both countries, therefore, share the challenges of a nursing shortage and large underserved communities for which health outcomes are below the national average. A collaborative approach to nursing education could help both governments respond to these shared challenges. Academic exchanges, common in the social sciences, could be established between U.S. and Mexican schools of nursing with the encouragement of the federal governments and, in the U.S. case, at state levels. There are a number of examples of state-level and private initiatives in the United States that could be emulated cross-border to help mitigate costs and enhance opportunities for exposure to technology, culture, and language that would make nursing graduates better prepared to work in multi-cultural environments on both sides of the border.[25] These could include allowing students to complete some of their coursework or practical experience in the other country through formal exchanges or mutual development of required coursework and training. A longer-term goal might be mutual acceptance of nursing credentials which would allow for a more flexible response to demand on either side of the border. As shown in Table 2, while 25 percent of U.S. doctors have foreign training, the comparable figure for nursing is only 6 percent. This suggests that foreign training is not an impediment to employment in the health profession and that there is considerable room for growth of the types of exchange programs described above.

The Way Forward: Challenges and Opportunities

Health outcomes in both Mexico and the United States are insufficient to achieve national development objectives including employment, productivity growth, and overall standards of living. During their successful presidential campaigns, both President López Obrador and President Biden prioritized healthcare with particular emphasis on underserved populations. While both leaders seem to view health as a domestic priority, both nations would benefit from taking a more “intermestic” approach to healthcare challenges. Collaborating, including through adoption of the recommendations in this chapter, would enhance both governments’ ability to improve health outcomes. Doing so would allow them to direct resources currently dedicated to health from treatment to prevention (which is almost always less expensive) and then to other national priorities (e.g., infrastructure, education, and workforce development). Through collaboration, both countries could capitalize on comparative advantages and, when appropriate, draw on past experience, to advance national health objectives. Further, a realigned binational health agenda could be fit into the 2030 SDG3 workplan to define and prioritize activities and set timetables, share indicators to track progress, and measure outcomes of improved collaboration.

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However, addressing the challenges identified in this chapter would yield more than just improvements in health outcomes. A bilateral collaborative approach could offer new mechanisms and venues to address other critical issues through a healthcare lens, especially if broadly defined. The existing and recommended health mechanisms, exchanges, and collaborative engagements provide an opportunity to improve awareness and understanding between public and private representatives of a sector accounting for nearly 18 percent of the U.S economy and about 5.5 percent of the Mexican economy. In addition, addressing these challenges can have a positive impact on other aspects of the economy and other domestic priorities. For example, addressing border crossing delays would reduce air and water pollution, which contribute to unhealthy living conditions for nearby residents while also helping to meet Paris Accord objectives. Enhanced cross-border training for nurses would provide a new source of higher paying jobs that would help meet workforce development and job creation objectives in both countries. Addressing migrant health in the country of origin through

multinational efforts to promote economic development in Central America as well as for those migrating northward would have important national security benefits. The rapid spread of COVID-19 across the globe underscores the potential pandemic risk that arises from the movement of people across national borders – whether through lawful or unlawful means. In short, addressing national challenges by enhancing collaboration in healthcare can yield multiple benefits for our nations.

Governments and individuals often consider healthcare spending to be excessive, inefficient, and unfair. The expenditures are immediate and growing while the benefits are diffuse and slow to accrue. Yet by viewing health and healthcare as enablers to address many of the policy challenges facing our countries, policy makers and their constituents may instead view health spending in a more positive light. Greater collaboration between our countries, in the public and private sectors, would allow both countries to deliver improved health outcomes at lower cost while contributing to greater understanding and awareness between our peoples.

Table 1. Comparative Statistics on Health Status and Risk Factors

	Mexico	United States	OECD
Population (millions, 2019)	124.9	328.0	-
Life expectancy at birth	75.4	78.6	81.0
Infant mortality 2017 (per 1000 live births)	12.1	4.8	3.5
Overweight and obesity (% of adult population)	72.5	71.0	58.2
Overweight and obesity (% of 5-9-year-olds)	37.5	43.0	31.4
Diabetes (type I and II among adults)*	13.1	10.8	6.4
Top 3 causes of death*	IHD Diabetes CKD	-IHD -Lung Cancer -COPD	-IHD -Alzheimer's and other dementias -Stroke
Top 3 health risk factors*	-High fasting plasma glucose -High BMI -High blood pressure	-Tobacco -High blood pressure -High fasting plasma glucose	

Sources: http://www.healthdata.org/results/country-profiles. OECD (2019), Health at a Glance 2019: OECD Indicators, OECD Publishing, Paris, https://doi.org/10.1787/4dd50c09-en.
(*) IHD- Ischemic Heart Disease, CKD- Chronic Kidney Disease, COPD Chronic Obstructive Pulmonary Disease, BMI – Body Mass Index

Table 2. Comparative Performance of Health Systems

	Mexico	United States	OECD
Health spending per person (USD PPP 2018)	1,138	10,586	3,994
Health spending (share of GDP)	5.5	16.9	8.8
Coverage of the core set of services (*)	89.3	90.8	-
Out of Pocket (OOP) (share of household consumption)	3.6	2.8	3.3
% of Households with catastrophic health expenditures	5.5	7.4	5.8
Hospital beds (per 1000 population, 2018)	1.4	2.8	4.7
Practicing doctors (per 1000 population)	2.4	2.6	3.5
Practicing nurses (per 1000 population)	2.9	11.7	8.8
Share of foreign trained doctors	n.a.	25	17.7
Share of foreign trained nurses	n.a.	6	5.9

(*) OECD (2019), Health at a Glance 2019: OECD Indicators, OECD Publishing, Paris, https://doi.org/10.1787/4dd50c09-en.

Endnotes

[1] https://www.pnas.org/content/112/49/15078

[2] https://www.thelancet.com/action/showPdf?pii=S2213-8587%2820%2930269-2

[3] The estimate of a border population of approximately 14.94 million refers to a border area limited to the 44 U.S. counties and 80 Mexican municipalities that have most of their population within the 100-km range.

[4] The health emergency response agenda also includes hurricanes, earthquakes, and other natural disasters that generate public health and medical care response crisis. We have not included this component which is traditionally best addressed by a domestic agenda.

[5] https://www.phe.gov/Preparedness/international/Documents/napapi.pdf

[6] See also: https://www.wilsoncenter.org/publication/pandemics-and-beyond-potential-us-mexico-cooperation-public-health

[7] The NALS have met on 8 occasions since 2005. The last meeting was held on June 29th 2016 in Ottawa.

[8] https://binationalhealthweek.org

[9]https://www.hhs.gov/about/agencies/oga/about-oga/what-we-do/international-relations-division/americas/border-health-commission/index.html and https://saludfronterizamx.org/

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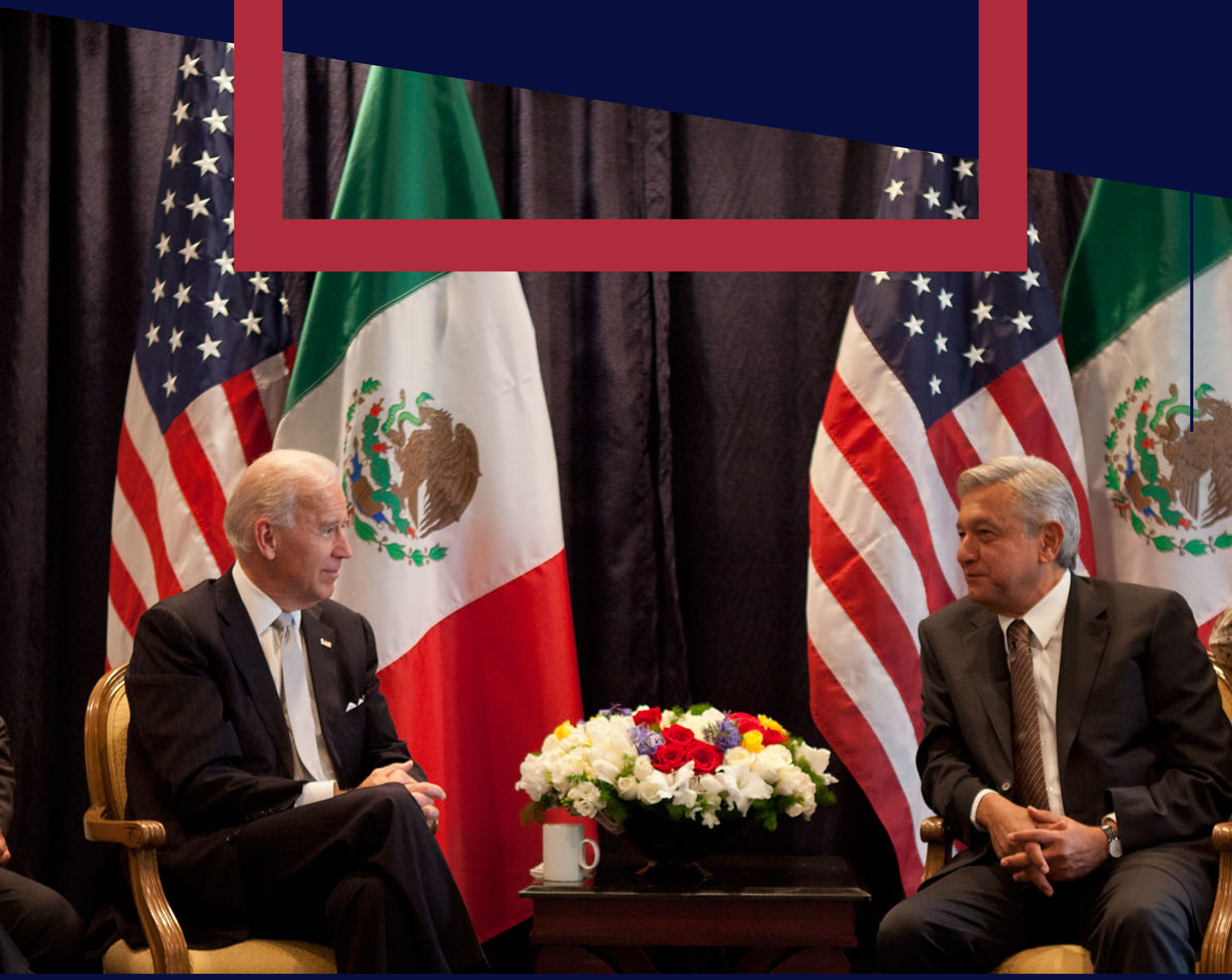
About the Authors

Eduardo González-Pier is a Global Fellow with the Wilson Center's Mexico Institute and is currently the team lead for UK Prosperity Fund sponsored Better Health Program in Mexico and a partner of Blutitude and Innovasalud, a healthcare advisory firm based in Mexico City. Formerly, he held the positions of Undersecretary of Health for the Federal Ministry of Health, Executive President of the Mexican Health Foundation - Funsalud, and CFO of the Mexican Institute of Social Security. He sits in the boards of several companies and foundations. With over 25 years of experience in the health and social security sectors, he has contributed to the development of health policy in Mexico, including major reforms, from varied high-level positions. His work focuses on providing sound evidence and analysis to inform policymaking and promoting mechanisms and tools to improve health system performance. He holds a PhD in economics from the University of Chicago.

Andrew I. Rudman is the Director of the Wilson Center's Mexico Institute. Before joining the Wilson Center, Andrew was Managing Director at Monarch Global Strategies (Monarch), a boutique strategic advisory firm located in Washington, D.C. and focusing on government relations and market entry/access for companies interested in doing business in Mexico and other Latin American countries. Andrew managed Monarch's healthcare practice and supported clients across a range of sectors and interests. He also writes and speaks on Mexican healthcare policy issues. Prior to joining Monarch in 2014 (then known as ManattJones Global Strategies), Mr. Rudman was Deputy Vice-President for the Western Hemisphere at the Pharmaceutical Research and Manufacturers of America (PhRMA) (2007 – 2014) where he was responsible for developing and executing policy advocacy strategies for member companies across the hemisphere with particular focus on Mexico and Brazil. Mr. Rudman began his professional career with the U.S. Government and served in the Department of State as a tenured Foreign Service Officer (1991 – 2001) followed by the Department of Commerce (2001 – 2006) where he was Director of the Office of NAFTA and Inter-American Affairs. Mr. Rudman has a master's degree in Latin American Studies from Tulane University and a bachelor's degree in Government and Spanish from Colby College. He is fluent in Spanish and has a working knowledge of Portuguese.



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