Globalization and Health at the United States–Mexico Border

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Objectives. We studied the impact of globalization on the making of health policy. Globalization is understood as economic interdependence among nations. The North American Free Trade Agreement is used as a marker to assess the effects of economic interdependence on binational health cooperation along the United States–Mexico border.

Methods. We observed participants and conducted in-depth interviews with policymakers, public health specialists, representatives of professional organizations, and unions.

Results. Globalization has not promoted binational health policy cooperation. Barriers that keep US and Mexican policymakers apart prevail while health problems that do not recognize international borders go unresolved.

Conclusions. If international health problems are to be solved, political, cultural, and social interdependence need to be built with the same impetus by which policymakers promote international trade. (*Am J Public Health.* 2003;93:2016–2022)

For multilateral organizations such as the International Monetary Fund (IMF), the World Bank (WB), and the World Trade Organization (WTO), globalization is a process characterized by the economic interdependence among nations created by increasing cross-border transactions of goods and services and of international capital flows. These organizations have been the major promoters of the current economic globalization process inspired under their neoliberal economic principles.[1,2]

An increasing number of researchers are examining the impact of globalization on international public health and health policy formation.[3–7] This article is an effort to contribute to the discussion of the consequences of neoliberal globalization on international health policymaking. The North American Free Trade Agreement (NAFTA), signed in 1994, signaled the beginning of an exponential increase of cross-border transactions of goods and services and of international capital flows between the United States, Mexico, and Canada. We wanted to assess the effects of the growing US–Mexican economic interdependence created by NAFTA on binational health cooperation along the United States–Mexico border. To this aim, we studied public health policymakers, people who influence policies, and health providers in Texas, New Mexico, and the 4 bordering Mexican states (Tamaulipas, Nuevo Leon, Coahuila, and Chihuahua). As we discuss, during many decades the United States and Mexico attempted to coordinate—with little success—health policies along their border in an attempt to resolve health problems that do not recognize political boundaries. Our leading hypothesis was that if economic interdependence were to have a positive effect on international policymaking, we would observe improvements in binational health cooperation along the United States–Mexico border.

The Setting

Approximately 11.5 million people reside in the 42 US counties and 39 Mexican municipalities located along the United States–Mexico border, and 86% of those people reside in 14 pairs of sister cities. Sister cities are metropolitan areas divided by the international border. On the US side, the population is predominantly of Spanish origin, young, and poor (35% live under the officially defined poverty level), and it is estimated that the population grows 3 times faster than in the rest of the country.[8] Compared with the rest of Mexico, the Mexican border population grows faster, is more affluent, and enjoys lower levels of unemployment. The border population is expected to double by the year 2020.[8]

Border residents share similar resources and environmental problems. Air quality, water quantity and quality, and animal control are issues of great concern for the border communities.[9–12] The American Medical Association has characterized the United States–Mexico border as a fertile ground for the development of infectious diseases. Rates of hepatitis A seropositivity on the US side are 3 times the national rates, while on the Mexican side the rates are almost twice the national one.[13] A recent study documented that the prevalence of hepatitis A among women visiting prenatal clinics in El Paso and Ciudad Juarez (the 2 largest sister municipalities) was 75.8% and 96.1%, respectively.[14] Along the Mexican border the incidence of salmonella is 26% above the rest of the country. In the United States, in unincorporated poor neighborhoods known as *colonias*, which comprise around 250 000 households, the rates of salmonella and shigella infection are 4 times higher than in the rest of the United States.[15] Tuberculosis (TB) is endemic on both sides of the border, and cases of dengue, leprosy, and rabies have been occasionally detected. Approximately 9% of the TB cases in the border region involve strains resistant to at least 1 of the first-line treatments.[16]

The communities along the border are economically and socially interdependent. Residents from both sides cross the border routinely to work, shop, visit friends and relatives, and purchase health services. There are about 1.1 million legal northbound crossings a day.[13] Valenzuela[17] describes the border residents as a floating population to underline its mobility and interdependence. The need for cooperation between the 2 nations for the purpose of improvement of health and environmental conditions is well known and has led to many collaborative initiatives between and within the public and the private sectors.[13,18,19] Unfortunately, most of these efforts have had limited success, in spite of the creation of a field office in 1942 by the Pan American Health Organization (PAHO)—the only one of its kind—in El Paso, Texas, for the main purpose of facilitating binational interventions at the border. If globalization is to bridge distances between nations, it could be

anticipated that the United States–Mexico border region, where there is intense contact and cultural closeness between the populations on both sides, is a place where the benefits of globalization would easily bear fruit.

Communities on both sides of this border have seen a phenomenal growth in international trade after NAFTA was signed.[19,20] This agreement does not include a health chapter, but many political leaders and economists consider it to be a model for the promotion of globalization in other parts of the world. The question we address in this article is whether or not globalization will facilitate the identification of solutions and the development of joint public health interventions to overcome problems that for many years have been identified as being of binational nature. In addition to public health problems that do not recognize borders, such as those related to environmental pollution, communicable diseases, and vector control, as well as the prevention of violence and motor vehicle accidents, there are other public health dimensions that need cooperative action and could benefit from increasing integration of the borders. Included in the last category are the design of binational disaster response plans, the organization of emergency services, the development of shared information systems, and a referral or information system to facilitate continuity of care when a patient initiates care in 1 country and receives additional care in a neighboring nation.

Researchers have documented the fact that border residents frequently cross the border to seek dental and medical services and to purchase pharmaceuticals.[21–25] The frequent movement of patients contrasts with the separation between the Mexican and US health care delivery systems. The differences in the organization and financing of the health delivery systems as well as malpractice laws have precluded professional collaboration or referral of patients to colleagues who work on the opposite side of the border. One of the expected results of globalization would be a better integration of the health care markets so that populations on either side of the border could take advantage of health services offered on each side and select those that are culturally, economically, or geographically more convenient. Existing and future bilingual-bicultural efforts to promote healthy lifestyles in the region could also profit from greater collaboration.

METHODS

Fieldwork for this study took place in 2 phases. The first phase was carried out between June 22 and October 30, 1998, and was conducted by 2 social scientists and 1 public health physician. A total of 82 persons were interviewed in addition to reviews by researchers of archival information. To avoid inhibition of respondents, interviews were not recorded on audiotape; instead, the decision was made that 2 researchers would attend each interview, 1 to record the responses and 1 to ask the questions. Notes recorded during the interview were transcribed immediately thereafter.

We were interested in eliciting the opinions of respondents in 4 categories: policymakers, representatives of groups that influence the policy process, experts from academic centers, and health professionals involved in binational border activities. Included in our sample were public health officers; elected state officials; municipal and county authorities; members of professional associations, including physicians, dentists, nurses, and pharmacists; academics; Mexican labor union leaders and political party officers (Partido de la Revolución Democrática, Partido Revolucionario Institucional, Partido de Acción Nacional, and Partido del Trabajo); officers of international organizations and of nongovernmental organizations (NGOs) with health programs; and representatives of business organizations. In Mexico, labor leaders had to be included because health professionals and civil servants are unionized and the unions play an important role in health policies. We attempted to interview the most knowledgeable and vocal person on health issues from each constituency (Table 1).

The semistructured interviews lasted between 30 minutes and 2 hours and were conducted at each interviewee's office. Interviews were conducted in the language preferred by an interviewee (English or Spanish). Most interviewees, even on the US side, preferred to be interviewed in Spanish. Because the information we wanted to elicit from each constituency was slightly different, we used 8 bilingual interview guides. The domains of inquiry included evidence and prospects of collaboration with counterparts on the opposite side of the border, priorities for cooperation, aspects that facilitate and preclude collaboration, and the impact of NAFTA on binational cooperation at the border.

The researchers selected US interviewees and the 4 facilitators assisted in the selection of the Mexican respondents. The Mexican facilitators were 2 academicians (1 from the School of Medicine, the Autonomous University of Nuevo Leon; 1 from the School of Social Work, the University of Tamaulipas) and 2 professionals (1 a political scientist, 1 a social worker) familiar with both the health sector and political institutions. The role of the facilitator was to collect existing documents, identify the interviewees according to the requests made by the principal investigators, and set up appointments. The researchers were able to meet with 3 of the 4 state secretaries of health in Mexico and with the Texas health commissioner. The rest of the interviewees occupied top positions in their organizations or offices. The state health secretary of 1 state (Tamaulipas) refused the interview.

TABLE 1—Characteristics and Percentages of Participants: June 22–October 30, 1998, and August 2001.

Employment/Affiliation	First Phase of Study, No.	Second Phase of Study, No.
Civil servants	28	24
Private sector (except NGOs)[a]	24	3
Political parties	13	3
International organizations	8	...
Labor unions	7	2
University faculty	6	2
NGOs	2	3
Total	88[b]	37[b]

Note. NGOs = nongovernmental organizations.
[a] Includes professional organizations such as medical associations, chambers of commerce, and professional practitioners.
[b] Totals may be greater than the number of respondents because some respondents can be classified in 2 categories.

The second phase followed the analysis of the data collected during the first phase; 35 public health authorities in Mexico were interviewed (August 2001) and additional archival materials were examined (i.e., federal and state laws, reports, articles, and newspapers) in the second phase. The format of the interviews adhered to the same guidelines used during the first phase. To maintain confidentiality, we only provide each interviewee's position but not his location. All direct citations in the text are from notes taken immediately after the interviews. Citations from Spanish interviews are our translations.

These data are complemented by participant observation as well as information obtained by the first author from 1998 to 2001 during her continuous residency on the border, and also from many informal meetings and conversations with dozens of health personnel and professionals on both sides of the border.

RESULTS

We do not have a baseline; therefore, it is not possible to compare the conditions found with those before the passing of NAFTA. Our findings indicate that since the passing of NAFTA, physicians in private practice in Mexico have easier access to US products and equipment but that cooperation between physicians on either side of the border has not improved. On the contrary, several interviewees who have resided in the area for at least a decade mentioned that cooperation became more difficult after NAFTA. Respondents provided many reasons why cooperation was not taking place. For analytic purposes we have classified barriers to cooperation between health authorities and professionals in 5 categories: political, professional, legal, administrative, and cultural.

Political Barriers

During the past 2 decades, many organizations began to use *border* to refer to their interventions, but generally their activities are implemented only on one side of the border. Thus, the Texas Department of Health (TDH) opened a Border Office in 1989, but its mandate was to improve health and environmental conditions on the US side only and by state law its field offices were not authorized to spend any resources in Mexico.

The interviews confirmed the paucity of *trans*border programs. A former director of the PAHO field office in El Paso indicated that there have been few transborder health activities and he added: "There are many meetings but few resources." The director of an NGO affirmed that there was very little binational cooperation at the border and commented that TB was the only field in which something had been accomplished, because US officials do not want the disease to spread north. A public health expert with 13 years of work experience at the border was very straightforward in his observation:

> The initiatives come from the United States, and when we spend any resources in Mexico we do it to prevent health problems generated there from having negative consequences for the United States . . . . Most agencies only work on their own side of the border . . . . The term *border* does not mean binational [italics added].

The priorities of US public health officers do not coincide with those expressed by their Mexican counterparts, and vice versa. The former director of the PAHO field office in El Paso clarified that for the Mexican government the health problems of the northern border are not a priority because the country has many more pressing problems in the south, and it would be natural to expect Mexican political leaders to support more public health interventions in those regions than in the north. For a Mexican director of a health region (*oficina jurisdiccional*), the difficulties in collaboration originated from the different approaches to public health that Mexican and US authorities have: "It is difficult to cooperate . . . each side has its own legislation and a different understanding of what public health ought to be."

A field officer at TDH explained that for the government of Texas, binational border cooperation was not a priority either. In his view, the success of transborder cooperation depends on those who work at the local level:

> There are many problems to overcome if one is to extend collaboration to Mexico beyond making it a symbolic act. For the state of Texas, transborder health problems should be resolved by the local communities, but the scarcity of local financial and human resources is not taken into consideration. On the other hand, the Washington bureaucrats make the decisions about the border and their decisions do not respond to our needs. The border/binational health problems do not give visibility to federal politicians . . . . There is no political interest at any level.

The director of an *oficina jurisdiccional* in Mexico expressed the need to cooperate with the United States, but suggested that the cooperation was rendered with extreme caution. "The so-called binational projects," he said, "are by and large US initiatives which do not take into account Mexican needs. The *gringos* were accustomed to come here and do whatever they pleased. Not any more. Now we say, How great that they have ideas, but before doing anything they need to come and consult with us . . . . First, we have to put our own house in order, we have to resolve our own problems." An official at the PAHO field station in El Paso explained that border activities initiated by the United States, such as the TB program Ten against TB, transmit a clear message: "We want Mexico to resolve the problem so that it does not become a problem for us."

Professional Barriers

Mexican providers in private practice, who expressed more interest than their US counterparts in the coordination of the provision of medical services, view their US colleagues as the main obstacle to binational cooperation. A faculty member of a prestigious medical school said,

> We extend courtesy invitations to US physicians and their teams and they come and provide care here at the hospital, but this is never done by [physicians from] the other side, there is no reciprocity.

A private practitioner was more damning in his views: "US physicians are very prone to steal patients. When we refer patients to US providers we lose them, they never refer the patients back to Mexico."

US physicians' perceptions of their Mexican colleagues expose the deep divide between practitioners on each side of the border. For a representative of a border county medical association, differences between the training of physicians in Mexico and in the United States are a problem: "It cannot be allowed that

Mexican physicians treat American patients." This point was questioned by a Mexican colleague who affirmed that 18% of patients treated on the Mexican side of the border come from the United States; most of them are persons without insurance. According to his information, the number of insured US residents who seek medical care in Mexico has decreased in recent years. "US physicians worked very hard to see that insurance firms did not include Mexican providers," this colleague said. Many studies confirm that US citizens and residents routinely purchase medical care from Mexican physicians, frequently for economic reasons but also because they prefer to be treated by Mexican practitioners.[21–25] Distrust by US physicians of their Mexican colleagues and animosity among US and Mexican private practitioners has been detected in previous research.[26]

NAFTA raised fears among Mexican practitioners. The representative of an association of general practitioners in Chihuahua voiced the fear that if US firms were to open clinics in Mexico, they would contract physicians' services without giving the national and local medical associations the opportunity of defending the financial and professional interests of their members. In fact, Mexican medical associations began to be more active after NAFTA due to physicians' concern that US health insurance firms and private hospitals that entered Mexico would exploit them. A recent study in Sonora also discusses the entry of US insurance companies in Sonora after NAFTA, and Sonoran physicians' fears that the Mexican health reform would privatize the health care delivery system. (Abrantes-Pego R, unpublished data, 2002.) If privatization were to occur, physicians thought, they would become employees of US companies that could exploit them. In Sonora, as in Chihuahua, physicians became politically more active and more organized after NAFTA.

Legal Barriers

Economic integration via NAFTA did not void legislation that impedes integration of public health programs, nor did it facilitate the creation of legal instruments to ease the design and implementation of binational border programs. Without those instruments, it is almost impossible for binational teams to make decisions jointly and respond in a timely fashion to perceived needs. Due to the absence of a legal framework, a TDH officer believed that the success of binational programs was up to local officials, who figure out how to operate the local system through informal mechanisms. In his opinion, success "depends on the interest of whoever works in the local office." According to the director of a binational project, the 2 federal governments had a tendency to paralyze state and local initiatives, but in his opinion there is a difference between them: The Mexican government is rigid and does not allow for a great amount of initiative at the local or state level, while the United States tends to be more flexible and looks in the other direction when federal regulations are stretched to resolve a problem that may threaten American citizens.

When legal mechanisms are absent and programs are left to the goodwill of officials, many efforts are lost when these officials leave office. In Mexico, a relatively large number of public health officials are political appointees and their tenure tends to be short, thus creating additional difficulties to successful implementation of health programs. Experience shows that attempts to create legal binational structures have evolved very slowly and have not been very efficient or successful.[27] The most recent example is the United States–Mexico Border Health Commission. The idea was formulated at the 1990 United States–Mexico Border Health Association meeting; it was approved by the US Congress in 1994 and received US funding in 1998, but due to a lack of understanding between the US and Mexican governments, it did not hold its first meeting until November 2000, the year that the Mexican government approved the Commission (executive director, US section of the Unites States–Mexico Border Health Commission, oral communication, March 25, 2002). The Commission has not advanced beyond discussions of the organizational structure and the decisionmaking process. As of September 2002, the mandate of the Commission continues to be vague. It is too early to know if the United States–Mexico Border Health Commission will accomplish anything, but the fact that it has taken more than 12 years for the idea to materialize illustrates that building official border binational institutions is a very lengthy process.

While there has been limited success in the creation of legal structures to facilitate integration, it can be affirmed that NAFTA has succeeded in creating bureaucratic norms that place additional burdens on transborder health programs. Several interviewees expressed this view. One of them affirmed that as a result of NAFTA the federal level was giving more attention to the border and that for border residents this attention meant "more norms and more rigidity in border exchanges, more bureaucratic red tape." He also said that "it has reduced, and in many cases eliminated, informal mechanisms of cooperation that existed before the Agreement." As an example, he mentioned the increasing amounts of red tape required in moving equipment and biological samples across the border, even for the implementation of binational priority programs such as TB programs.

US state and municipal funds cannot be spent in Mexico; only the US State Department can authorize the allocation of public funds to foreign countries. These restrictions create insurmountable barriers to border cooperation. One municipal health official used the following example:

> When there was a hemorrhagic dengue epidemic in [name of the Mexican city], the regional health officer called me at the request of his state secretary of public health asking for assistance with equipment and insecticides because the Mexican federal government was not able to help. I had to say no, because we cannot send equipment or funds to the other side, the only thing we could offer was technical assistance . . . . I told him to call PAHO.

The municipal health official was well aware that the control of dengue across the border was an important preventive measure to protect US residents. In contrast, in the past, neighboring municipalities—sister cities—collaborated routinely in mosquito control and other public health activities (i.e., immunizations, emergency response, control of infectious diseases).

Some of the legal impediments can be overcome by channeling funds through international organizations such as PAHO, the United States–Mexico Border Health Association, and private foundations. Foundations and NGOs have been organized for the sole

purpose of allocating US public funds to projects in Mexico, but it is not unusual for funds to go through 4 or 5 organizations before reaching their final destination. This process slows down cooperative efforts, increases costs, and overstates the role of NGOs at the expense of the public sector.

Legal restrictions go further. In theory, state and local officials require federal authorization to cross the border for official purposes, or even to make official international telephone calls. The director of a US NGO mentioned that she needed authorization from Washington to make phone calls to Mexico when using federal funds. When calling Matamoros from her office in Brownsville, she preferred to route her calls through the PAHO office in El Paso. Often the US government overlooks some of these restrictions, but there are many gray areas and uncertainty regarding what states, counties, and municipalities can and cannot do. The confusion is such that in 1999 the state of Texas requested a report to clarify federal and state laws inhibiting the exchange of epidemiological reporting between Texas and Mexico and cross-border binational health cooperation.[28] The situation is similar in Mexico. The director of a health region explained that he could not share the epidemiological reports with US county officers until he received state and federal authorization.

Administrative Barriers

Health personnel have identified the behavior of custom officials as a serious constraint in solving binational problems. Even when the federal governments of both countries issue specific rules to custom and immigration agents to facilitate binational health cooperation, local border agents can interpret the directives differently. The interpretation can be at times capricious, even despotic, and frequently is inconsistent and erratic. Public administration theory identifies the power of interpretation as the discretionary power of the bureaucracy, and it is especially so when custom and immigration officials deal with foreigners because complaints can only be solved through slow and ineffective diplomatic channels. In a final analysis, at the border the officer on duty is the one who decides if patients, equipment, materials, and biological samples can cross the border, have to wait until clearance is received, or are sent back. Delays, denials of border crossing for treatment, and questionable tariffs are some of the consequences that on more than 1 occasion have complicated or terminated cooperative efforts. A TDH field officer has said:

> Customs behavior is very capricious, if they know and like you, you can do anything, . . . if not, it is impossible to work. Each thing that we take through customs is handled differently . . . it is difficult to reduce red tape. Binational agreements do not facilitate things. . . Everything takes a lot of time and things get complicated. . . Mexican customs change the rules of the game constantly. . . They ask for more and more papers and since the norms are not written anywhere it is not possible to protest or to know to whom should we address the complaint.

A PAHO official commented that "a critical problem for cooperation is the lack of information, and when the information is available it is not accurate or comparable." Variations exist in how diseases are identified in the 2 countries; for example, the requirements to confirm a reportable disease case may be different in the United States than in Mexico. This problem is being tackled by a project that is developing common definitions and procedures for laboratory confirmation of a selected number of infectious diseases.

Cultural Barriers

As indicated, large percentages of the populations on both sides of the border are ethnically similar and many persons are bilingual. Despite this fact, the political boundary creates and reinforces cultural differences. Our in-depth interviews uncovered a profound distrust between decisionmakers and health workers on both sides of the border. Perceptions of one another are negative, not only among public health workers and officers but also among private health and business professionals. Mexican professionals resent the arrogance of their US counterparts—including those of Mexican descent—as well as their self-declared superiority and racism, while US respondents criticize the lack of organization, corruption, and low level of training standards in Mexico.

The words of a director of regional heath services in Mexico are very indicative:

> There is a lot of racism on the other side. The United States needs to acknowledge that they have many problems, including health problems. The legal barriers, yes we could eliminate them, but it is a matter of politics to protect national sovereignty. We Mexicans are poor but proud. The *gringos* should respect the Mexican laws. At times they do not allow certain things, then we should not allow them either.

A Mexican state health secretary complained that 1 staff member at TDH convened binational meetings without first checking the secretary's availability. "I would like to attend the meetings," he said, "but I cannot always cancel the commitments I have previously made." Perhaps the TDH staff member assumed that the schedules of Mexican health secretaries were less important (because Mexicans are inferior) than the schedule of the Texas Health Commissioner and, therefore, could easily be changed.

The US and Mexican health care systems respond to different societal values. In Mexico, as in many other countries, health care is based on solidarity; that is, on the principle of a national health system. In the United States the organization of health care responds to a principle of individualism and laissez-faire that has created a fragmented health system. A professor at a leading medical school could not envision how the 2 countries could cooperate because he said "they are 2 systems entirely different . . . at all levels."

Other, more subtle cultural differences create communication difficulties and frequent misunderstandings, with negative consequences for collaborative work. US professionals use direct, straightforward language that at times may be perceived as offensive, while Mexicans tend to use more diplomatic expressions in efforts to minimize offenses. Professional transactions are formal in the United States, but for Mexicans the social dimensions of professional relations are very important. In the United States, information tends to be shared, but in Mexico nonpublished information is zealously guarded.

The tendency to impose US values on cooperative binational efforts is very subtle but real, and some Mexican counterparts are aware of it. The problem of cultural diversity is difficult to overcome, and becomes even more difficult when 1 side considers its culture to be superior. One university professor at a leading Mexican medical school that receives medical residents from many foreign countries, including

from European universities, pinned down this feeling when he commented:

> There is the view that they are the scientists, we are only the manual labor, the peons of medical care. There is always that feeling of contempt toward Mexico, but the difference is technological and financial, not of scientific knowledge.

Cultural barriers are perhaps more difficult to overcome than other barriers because they tend to be subtle or even hidden. At times, because it is politically incorrect to express discriminatory perceptions, true feelings are not manifested. What is not acknowledged cannot be resolved. In addition, the historical legacy of the Monroe Doctrine[29] and continuous US intervention in Latin America create a natural disposition in Mexico against US domination and imposition of policies when the self-interests of the 2 countries do not coincide.

CONCLUSIONS

In spite of emerging linkages, we found very few truly binational cooperative programs along the US–Mexico border. The leading assumption of our research was that NAFTA would facilitate border binational cooperation and, as a result, would contribute to the improvement of the health status of border residents. The barriers to collaboration that we uncovered in our research suggest the opposite: US health officers and practitioners and their Mexican counterparts face a variety of constraints that impede the design and implementation of meaningful cooperative health programs. Among health professionals, globalization has had little effect in bringing them together and in overcoming national jealousies, suspicions, or tendencies to protect their professional turf.

Our study shows that globalization has not helped to improve health cooperation between the 2 federal governments or between neighboring states and municipalities. Border states and municipalities are not allowed to carry out joint programs of mutual interest, and even the exchange of basic epidemiological and health information continues to be problematic. Border public health experts indicated that NAFTA brought additional bureaucratic hurdles that, in some instances, rendered collaboration through informal exchanges more difficult.

Our findings cannot be extrapolated to other settings. Nevertheless, they suggest that if globalization fails to resolve common health problems along the United States–Mexico border, where residents interact greatly and share a culture, it will not be likely to succeed in improving international health policymaking among populations that are culturally, linguistically, and geographically more distant.

Technological innovations and social changes have made global economic interdependence possible, and reversal of this process is unlikely. It would be desirable that the benefits of economic interdependence produce better standards of living and health for all. Unfortunately, a growing body of literature confirms our findings and suggests that better standards are not the case. In their study of the impact of globalization on health, Unwin et al.[30] expressed this view:

> Economic orthodoxy asserts that globalization is both inevitable and desirable: interfering with the free movement of capital hinders the very processes that will bring better standards of living and health for all. A counterargument is that what we are seeing at the moment is very far from free trade, but a world economy increasingly dominated by a small number of multinational giants able to dictate the conditions of trade.[p1401]

One of our respondents, a field officer of TDH, identified the same beneficiaries of globalization at the United States–Mexico border: "NAFTA only works for the large corporations, and for nobody else."

That transnational giants are the primary beneficiaries of globalization explains in part why globalization has not improved public health. There is no consensus,[31] but an increasing number of studies have documented a trend in which growing economic interdependence and movement of capital favor the wealthier citizens of all nations[32] and worsen the income distribution among and within many countries.[33] The negative correlation between poverty and health is well established.[34–36] Therefore, the links between globalization, poverty, and the lack of impact on health are firmly established.[1]

To reverse this trend and break these links, it is necessary to redesign the current globalization model and the principles upon which it is built, which is not an easy task. Replacing the neoliberal globalization, as critics like to label the current model, with a more humane or humanitarian model implies major modifications to powerful international institutions that include the IMF, the WB, and the WTO. Economic growth and increases of free trade and capital flows cannot be the ultimate goals of globalization, as is now the case; instead, improvement of the well-being and health of the global population should be at the top of the agenda.

From our study it is possible to suggest that to improve the health conditions at the border, it is first necessary to overcome the barriers to political, cultural, and social interdependence. So far, federal and state policymakers in the United States and Mexico have not given a high priority to the resolution or even to the understanding of these barriers and their impact. In the building of a global society, the order of factors should be reversed: political, cultural, and social interdependence need to be built with the same impetus given to economic growth and should predate or at least go in tandem with the development of international trade. ■

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N. Homedes and A. Ugalde jointly designed the study, collected the information, analyzed the data, and wrote this article.

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Human Participant Protection

The study was approved by the University of Texas, Austin, and did not require the full review of the institutional review board.

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