An Exploration of Tijuana – San Diego Marketing Environment and Marketing Border of Health Service in Tijuana

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Abstract
Tijuana is considered one of the strongest markets throughout Mexico and is a highly mobile consumer market. Differences in costs, availability and quality of medical and health care between the two countries, Mexico and the U.S are abysmal. Today trade in health services is important and it gives the rapid growth to the industry's overall health sector. There should be removal of some regulatory barriers in services health trade at the regional levels multilateral and national trade in the near future. This paper defines the trans-border market of the Tijuana - San Diego health services. Medicines and pharmaceuticals are reviewed briefly as the main marketing practices from the globalization of economic processes of globalization. Also more specifically the opening of the Free Trade in North America (NAFTA) comes in the following details.

1. Background

In the last two decades, globalization has affected all sectors directly or indirectly. Driven in part by technological advances and the political & economic upheavals, the process of globalization has led to the emergence of new forms of opportunities, business processes and organizations. The health sector is one of those areas that have been significantly affected by economic globalization despite its good public nature, however not a good commercial one.

The services sector health care is among the fastest growing sectors in the global economy, which is estimated at about $ 3 billion annually. Just in the OECD countries it is expected to rise to 4 trillion to 2005.

The globalization of health services is reflected in the emergence of new forms of organization for health care in the last decade and increased cross-border delivery of health services through the movement of goods and services. A global restructuring in the health sector due to high costs of medical services, particularly in developed countries has resulted in the creation of an international market of care and health care.

International trade is an economic activity that benefits the countries that allow focus on producing those goods and services in which they have comparative advantages and competitive advantages in terms of natural resources, labor, capital, technology, etc. Production costs are reduced achieving economies of scale. Finally, international trade provides an access to products that meets a wide range of tastes; however, regarding these factors, the international trade support arises from a deeper principle, and is of comparative advantage according to which each country tends to specialize in the production and export of such products and services that can be produced relatively cheaply. Free trade areas allow additional activities that are taking place within its borders and that reinforce the comparative advantages of the countries involved.
International trade in health services in developing countries has appeared on the scene not only as a means of supplementing their income but also as a way to strengthen and increase national health services. The high content of labor, capital and skills in health services provides an opportunity for developing countries, considering that it can maintain the necessary quality standards.

The term export of health services refers to the movement of diagnostic information, such as results of laboratory tests, interpretation of biopsy, electrocardiogram, X-rays, CAT scan and others, or therapeutic information, for example, treatment recommended following the review of patient medical records among health professionals and institutions in different countries. As mentioned previously, this export can take place electronically, satellite, by mail or by transport (Gomez-Dantes, Frenk and Cruz, 2007) except in certain border regions where it is still rare, and its development requires an appropriate communication infrastructure shared by suppliers located in several countries; also thay should be involved in a standardized patterns of patient referrals to ensure reliability and the information sent.

The globalization of health services is driven by two factors. First, the decline in public sector spending on health services, and on the other hand, increased private sector participation in health care in many countries, liberalization of related sectors (such as insurance and telecommunications) which increase the mobility of consumers and providers of health services due to the decline in travel costs and greater ease of travel and the technological advances that allow many cross-border deliveries of health services.

The international consumer movement in health services involves crossing an international border at least, from one country to another, for the purpose of obtaining health services. In the balance of payments of U.S. national accounts in the service and entered catearía export of medical services, in what is defined as revenue generated by hospital patients traveling the country to receive some form of medical treatment, Organization for Economic Cooperation and Development (1992). Fortunately for the industry sector of health services due to its universal basic knowledge and despite the differences in certification and licensing procedures, the quality of medical services is getting to be similar in almost all countries, with costs as the biggest difference.

The differences in cost, availability and quality of medical care and health care between the two countries, Mexico and the U.S. are abysmal. The emergence of investment opportunities in the sector of health care increases with the processes of liberalization and deregulation on investment, and the general increase in demand for health services arising from increases in income levels and ages of the individuals, are also factors that have contributed to the globalization of health services. The best public and private hospitals have established connections with each tros hospitals, laboratories and universities abroad. Large companies and transnational corporations operating in the areas of hospitals and health insurance may abuse market power and take advantage of the lack of regulations.
Although trade in health services is important today given the rapid growth of the industry's overall health sector and the removal of some regulatory barriers to such trade at the regional levels, multilateral and national trade in services health will have more relevance in the near future. It should nevertheless be considered, to

ensure that the growing processes are fair and open competition in the market is carried out in the most efficient way; the state should consider the option to play a more crucial role as service provider health and as a funding source, while expanding its role as a regulator.

The international movement of health service providers involves at least one crossing, once the international border and go from one country to another for the purpose of providing health services. This type of interaction provides an opportunity to improve access to health services that few in the area are able to use for a variety of economic and cultural reasons, including lack of resources and familiarity with the language. Moreover, the movement of suppliers tends to serve as a significant source for transfer and international exchange of clinical procedures and knowledge among doctors and hospitals. To maximize the effectiveness of this type of interaction, the criteria used to license and certify health care providers' brutality in the various countries involved need to be standardized.

Trade in health services via external consumption also has some implications. On the positive side, you can allow exporting countries to make improvements in the national health system by generating or currency exchange gains and additional resources for investment in this sector / tambe can help in improving its infrastructure and health care health, knowledge and medical skills, technical skills, in estuaries national health service, etc. For countries that health care services through external consumption, this may be an important means to resolve human resource limitations and physical, particularly for specialist services in public health. The availability of good quality and the potential acquisition of treatments in geographical proximity is often an important criterion in such cases.

Developing countries consume an estimated 25 percent of medicines in the world. Despite the weak market, developing countries are subject to powerful marketing practices of multinational companies.

According to past trends, there is need to understand the implications of globalization on health services for the realization of social development goals and the potential for negotiations between these and commercial sector needs considerations. This understanding will enable governments to balance the concerns of the competition.

Trade in health services have strong regional dimensions because it is limited only to trade between neighboring countries for the San Diego-Tijuana border region and is also an important aspect of trade within the trading bloc of the Free Trade of North America (NAFTA). The 5 chapters of NAFTA that relate directly to trade in health services i.e. XI, XII, XIV, XVI and XVII, respectively deal with investments, cross-border services, financial services, temporary entry of business people and intellectual property. The content of each chapter describes the basic types of trade in health services (Ministry of Trade and Industry, 1994).

Some countries have made concerted efforts to create regional markets for trade in health services, even outside the formal regional trade arrangements. Trade in health services in various matters such as recognition, standards, portability of insurance, etc., which must be negotiated in this trade have been discussed in the context of arrangements of NAFTA as part of its initiatives for a more extensive to liberalized trade of health services in the region.

Health services have been a very sensitive issue within NAFTA, taking into account the different health systems that exist in the U.S., Canada and Mexico. The needs, interests and attitudes of the member countries in this sector have been very different. While the U.S. seeks the harmonization of the three systems, this process has been resisted by Canada and Mexico (USITC, 1999). This has resulted in a limited number of initiatives to address regulatory measures related to trade in medical services. However, evidence suggests that trade in health services in its various forms has been stimulated by the formation of the regional bloc.

NAFTA has provided a temporary movement of

service providers within the region. However, this excludes the movement of care professionals and health care. Doctors and paramedics are allowed to enter the United States to Mexico in extreme situations and emerging. The movement of medical and nursing staff is not allowed freely. The free movement of doctors and paramedics, mostly from U.S. to Mexico, is allowed only upon request and in extreme situations such as floods, earthquakes, etc.. NAFTA does not include, among the professionals mentioned in the agreement, free movement of doctors. According to TLAN professionals wishing to work abroad they must meet the requirements.

The mobility of suppliers in this sector remains subject to regulation by the host country where professionals want to work. This includes licensing and certification required by the host country to be eligible as a practitioner. These procedures and requirements are very different between the three member countries and to date there has been little progress in harmonizing them.

In Mexico, obtaining a permit is a federal and national equipment and professionals are allowed to practice in any state based on national license, while in this U.S. and Canada, regulations vary among states and provinces, respectively, and the professional associations play an important role in ensuring the quality and standards. Although the NAFTA countries agreed to continue with existing regulations and provisions in the licensing and certification of health services, in NAFTA provisions were included to encourage cross-border mobility of health service providers and facilitate recognition mutual skills and training between countries. For example, NAFTA annex on the mobility of health service providers requires the professional bodies of member countries to discuss the criteria related to professional licensing and certification of providers of health services is targeted to some extent possibly to regional harmonization in the delivery of care and health care. These provisions are found in Chapter 12 of NAFTA contains an article and an annex on mobility between member countries of the health service providers. Furthermore, in January 1996, all requirements of citizenship and permanent residency for the Professional Practice of NAFTA were removed although the recognition was not automatic yet.
The agreements allowed the health service providers to choose freely where to provide their services without being subject to requirements of establishing a representative office or branch. NAFTA also contains provisions to facilitate the temporary entry of business people, including doctors and their partners for educational and research purposes subject to quota limits specified. While the provision does not amend existing immigration and labor market regulations, simplify entry procedures by removing the scope for discretion of the officers of the border to deliver visas to doctors.

In the case of nursing, the trilateral initiative is a collaborative venture effort between the nursing staff directed to work toward developing mutually acceptable standards for licensing and certification of nurses and harmonization of standards, ensuring non-discriminatory treatment to each one to the other nursing staff and have clear, measurable and verifiable, licenses and admissions requirements.

NAFTA also contains a provision to facilitate FDI in the sector of health services within the region. Up to 100 per cent of foreign investment is allowed in hospitals and clinics. Although there have been no specific initiatives to promote direct investment in health services under NAFTA, the evidence indicates that cross-border establishment of care facilities and health care has grown after implementation of NAFTA. There is growing interest among U.S. firms to invest in the public sector in Mexico, particularly in hospitals, clinics and HMOs. U.S. firms have established facilities for health care in different Mexican cities.

The directory of companies in the grouping of medical products confirms the presence of 61 companies and Baja California in the sector representing 27 thousand jobs. The health care sector in Baja California is composed of 451 clinics and hospitals, 318 specialized laboratories and drug distributors. (Elorduy Walter, 2003)

2. Delimitation of the Southern California border market – Northern Mexico.

In the years since the Treaty of Guadalupe in 1948, the border of Mexico and the United States has experienced a steady flow of people and goods. The border region Tijuana - San Diego is a geographical region that has evolved as binational and coexists with integrated social and economic areas.

The frontier of California-Baja California is home to 40 per cent of the total population living in the border between Mexico and the United States. The San Diego-Tijuana binational region has evolved over time. An intense urban development and a continuous flow of people and products have transformed communities in this border in a region with distinctive social interactions and relationships, and unique political economics. These characteristics have an impact on the physical and social development.

The political climate in the region of San Diego-Tijuana border is often highly contentious. Every day there is a huge concentration of pedestrians in crossing as the Tijuana border is home to many binational families with members working in the United States and living in Tijuana for the lowest cost of living and the mixture of the nationality of their families. Along with this intense daily migration from south to north there is a reciprocal flow southward from Mexican nationals living north of the border and traveling to Baja California for food and services as well as to maintain family ties, neighborhood and friendship.

The San Diego-Tijuana region covers the northwestern Mexico and southern California, where there are developments in telecommunications, biotechnology, manufacturing, etc. The border region San Diego-Tijuana has one of the ideal climates in North America. The quality of life of San Diego is considered one of the best in the world and the highest in the United States. These factors coupled with world-renowned universities and research institutes in San Diego, has attracted technology companies in biotechnology and telecommunications in the region.

San Diego is a center for high technology innovation, has incubated many of his own and growing companies. San Diego is considered the Silicon Valley of biotechnology and telecommunications. The defense industry also plays an important role in the economy and manufacturing for its great contribution to regional gross domestic product. San Diego is famous for its climate and fabulous beaches. Tijuana is one of the world's most competitive manufacturing centers for businesses of intensive labor, which has attracted many European and Asian companies.

The San Diego - Tijuana is the largest region of the US-Mexico border with a combined population of over 4 million people. The port of entry to the U.S., San Isidro and Tijuana is the busiest in the world, with over 55 million crossings in 2000 (Annual Border Health Status Report, 2000). The total Hispanic population of San Diego-Tijuana is 2, 520, 835 and total Hispanic households is 610, 720. The percentage of Hispanic density is 56.1 per cent or almost three of every five people in the region are Hispanics (San Diego Dialogue, 1999; Tijuana Estimates DMA, 2002).

The Hispanic population in San Diego is only 927, 600 with a density of 31 per cent per cent. Greater than one in every three people in San Diego County are Hispanics with a total of 204.200 households. The population growth of Hispanics in San Diego from 1990 to 2003 accounted for 71.3 per cent, and represents the consumer group that has more growth. For the year 2036, the Hispanic population in San Diego County represents the largest segment of the population (Live Births by Race / Ethnic Group of Mother, California Counties and Selected City Health Departments, California, 2002).

The total population of Tijuana is 1,593,235 inhabitants with a total of 370.520 households (DMA Tijuana Estimates, 2002). The population is distributed by 90 per cent in Tijuana, 6 per cent in Tecate and 4 per cent in Rosarito (Strategy Research Corporation, 2000). The occupation is distributed as per cent white collar 54 per cent, blue collar 36 per cent, per centunemployed 7 per cent and per centothers 3 per cent (Hispanic

Marketing Research Corporation, 1990 - Tijuana Market Study).

The median household income in San Diego in 1999 was $54,438, compared with the average income of $33,433 of Hispanics in the county. Economic disparities are evident when looking at poverty levels. The poverty rate across the county is 12 per cent while that for Hispanics is 22 per cent (U.S Census Bureau, 2000). Despite the economic advances, the San say and Tijuana, both communities are still plagued by increasing problems of social and economic inequalities between rich and poor. The most critical issue for residents of the San Diego Tijuana border region is the low health standards and low socioeconomic status when compared with the rest of California and the United States. The availability of lower cost of cross border services in Mexico is thus perceived as a viable economic alternative source of health care.

The economic disparity between rich and poor in San Diego and Tijuana is expanding and is making great areas of poverty in both communities. While the nature of the degree of poverty is different in San Diego to Tijuana, the poor in both communities suffer from lack of access and availability of services to meet their health needs. Another growing concern is the crime that is exacerbated by the economic challenges of urban poverty faced by both communities.

The urban and rural poverty is increasing on both sides of the border in selected communities of the City of San Diego, and Barrio Logan, San Ysidro, Southeast San Diego, in South County as National City, and North County, Vista, San Marcos, Fallbrook, Rainbow and Oceanside. All these are communities with significant numbers of migrant workers from Mexico and Central America who are less inclined to return to their place of origin with the recent increase in surveillance of the border since Operation Gatekeeper.

According to a recent report by the institution, San Diego is now sixth in the nation among metropolitan areas that have had sharp increases in poverty according to census traces in their respective regions (Jargowky, 2003), A review of Mexican Consulate in data consular San Diego County reveals a positive correlation between those areas experiencing increases in poverty with those having a high concentration of Mexican migrant workers (Rungsted, 2003).

In Tijuana, urban poverty is rising to alarming proportions with half of the new residents living in communities without adequate infrastructure, no or very limited clean water, thus polluted water causes infectious diseases. Although the unemployment rate remains low in Tijuana, the cost of living is high. The actual value of the minimum wage in Mexico declined substantially and continuously in the last two decades by over 60 per cent. Income distribution in Mexico is one of the most unequal in the world, with the poorest earning approximately 3.5 per cent of total national income (United Nations Center for Human Settlements, UN Habitat, 2001).

The very wide disparity of income in Tijuana helps explain the growth of urban poverty and informal settlements in this economically prosperous city in northern Mexico border. Despite the growing challenges of irregular communities of Tijuana, measured progress is achieved through the efforts of a select number of nonprofit organizations in San Diego and Tijuana lucrote. However, given the complexity of human service needs in illegal settlements in Tijuana, but nonprofit partnerships are needed between different sectors. Unfortunately, as in Tijuana, economic disparity among the wealthy and the poor is becoming more pronounced in San Diego.

Tijuana, like San Diego has economic statistics that are impressive. According to Jargowky, 2003, the city has a per capita income in purchasing power parity of $ 9,800 per year, far above the 7,500 national averages. Although Tijuana has recently lost jobs because of the closure of countless maquiladoras by competition from China, the city has a relatively low unemployment rate of less than 2.5 per cent. Tijuana has been able to attract the firm Toyota Motors to establish its presence in the region. In relation to other parts of the Republic of Mexico, Tijuana is still going to be a city of opportunity.

The flow of cross border consumer is based on geographical proximity to the host country market and is concentrated in towns and cities on both sides of the border between Mexico and the United States. However, according to Marv Shepherd (cited by Hawryluck, 2001) from 25 to 40.5 percentages of U.S residents travel to Mexico bring back prescription pharmaceuticals. In its survey found that not only quines live near the border with Mexico but came from 37 states including Washington, Maine, Minnesota and Massachusetts. People travel because most drugs are sold over the counter in Mexico.

Interestingly, due to proximity, some of the shortcomings of health systems in the United States are being covered by private health services in Mexico, which in this form, is opening opportunities for trade. Besides the advantage of location and geographic proximity, the border region also has a development potential for international trade in health services. The Hispanic market in San Diego - Tijuana has a total purchasing power of $15.1 billion dollars annually, of which $12.6 million for thousands of San Diego and $2.5 billion to Tijuana. This represents over $41.4 million dollars in spending a day in San Diego (San Diego Dialogue, 1999, Synovate, 2004).

The Hispanic market is the third longest in the United States. Hispanics also referred to as Latinos are the ethnic minority group fastest growing and second largest in the United States. In 2000, 11.4 per cent of the U.S. population was Hispanic. The Census Bureau projected the U.S. in 2010 to 13.8 per cent of the Hispanic population will be 20,050 for 24.5 per cent against a population of African Americans from 15.4 per cent (Day, 1996).

The purchasing power of the Hispanic market in San Diego is 12.6 billion dollars annually, representing more than $ 34.6 billion daily spending (San Diego Dialogue, 1999). The average household income is $57,038 annually (Global Insight, 2003). The San Diego market is considered one of the most affluent markets economically out of all the Hispanic markets. Only the San Diego Hispanic market, without taking into account the de Tijuana, is the 11th largest in population and the tenth largest in retail sales in the U.S. (San Diego Dialogue, 1999).

The consumer market of Tijuana has a total purchasing power exceeding $3.0 billion annually in the County of San Diego. This is an estimated $5.5 million minimum daily expenditure of Tijuana (San Diego Dialogue, 1999). The Tijuana represents 8 per cent of all retail sales in San Diego, generating millions of dollars in revenue for local municipalities (DMA Tijuana Estimates, 2002).

Tijuana is considered one of the strongest markets throughout Mexico and is a highly mobile consumer market. The purpose of travel from Tijuana to the United States is related to purchases 42 per cent, per centworked in San Diego 24 per cent, per centothers 19 per cent, per centsocial visits 11 per cent and per centtourism 4 per cent (San Diego Dialogue, 1994). The products purchased in San Diego make up per cent clothing and footwear 79 per cent, foodstuffs 44 per cent, per cent household appliances 27 per cent, electrical equipment 10 per cent, per centauto parts 3 per cent, furniture 3 per cent, per cent cosmetics and perfumes 3 per cent, per centrented films and tapes 2 per cent, per centoffice equipment and gifts 2 per cent, per centaccessories 1 per cent, jewelry (SRC San Diego Hispanic Market Study, 1989).

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