MIGRATION AND DEVELOPMENT, VOL. 10, NÚM. 19, 2012, 5–29

HEALTH CARE POLICIES. BIOPOLITICAL STRATEGIES USED TO CONTROL MEXICAN MIGRANTS IN THE UNITED STATES

FERNANDO FARFÁN*
IVONNE VIZCARRA**
NORMA GONZÁLEZ***

Abstract

This paper analyses health care policies aimed at Mexican migrants headed for the United States. The goal is to understand how these policies respond to strategies meant to control migrants' access to and stay in the country. This is approached via Michel Foucault's notion of biopower: a power that aims to subject bodies and control populations via a number of techniques and strategies. In this sense, public health care policies constitute a vehicle to control Mexican immigrants traveling to the United States. Said policies' modes of action and scope are addressed; moreover, they are examined in the context of global mechanisms used to govern the Mexican migrant population.

Keywords: Biopower, biopolitics, migration, health care, government.

* Professor at the School of Medicine of the Autonomous University of Mexico State (UAEMex).
** Professor and researcher at the Institute of Agricultural and Rural Sciences at UAEMex.
*** Professor and researcher at the School of Political and Social Sciences at UAEMex.

INTRODUCTION

Migration between Mexico and United States has been addressed from a variety angles: the study of remittances looks into how Mexican workers travel to the United States to obtain employment and thus ensure their survival and that of their families. Heredia (2011), Delgado, Márquez and Rodríguez (2009), and Levine (2006) have all addressed the working conditions of migrants and the escalation of U.S. migration control policies, from more severe laws to increasingly sophisticated technological monitoring mechanisms. Health care policies that also seek to control the flow of migrants have been implemented, limiting their access through more subtle mechanisms such as the Vete Sano, Regresa Sano (Leave Healthy, Come Back Healthy) program, which registers health conditions in places of origin, transit and destination (SSA, 2002: 27). A similar trend can be seen in the increasingly drastic requirements for obtaining immigrant visas to the United States.

However, the main biopolitical measure against this population is the exclusion of health services, even when the jobs are performed in companies lawfully listed by the U.S. government (Ponce, 2012). The counterpart is the "omission" of these restrictive policies when there is great need for workers (Massey, 2009). These everyday issues in the relationship between Mexico and the United States constitute a biopolitical strategy employed by both governments. Foucault describes biopolitics as a power that not only represses but also seduces, facilitates, hinders, extends, limits and, of course, forbids (Foucault, 2008: 148).

Given that health is one of the essential requirements for a good labor performance, the state seeks to control it in order to guarantee its full exercise of power and legitimacy, as well as practice, if necessary, its monopoly of violence to perpetuate the social order. This paper reflects on the following hypothesis: in the 17th century, sovereign power belonged to those who could guarantee the life of their subjects by exercising the power of life over death. Today, power can ensure life through a reverse technology that consists of enabling life or letting die (biopower); its exercise comes from a democratic rather than monarchical government, impacting populations by controlling bodies and life in general (Tejeda, 2011).

The purpose of this paper (the product of published research, texts and discussions) is to use the concept of biopower to take a critical view of current Mexican migration and enrich interpretations on power and health care policies as mechanisms utilized by the state. Our first section addresses the concepts of biopower and biopolitics in their various manifestations, from their beginnings to the late 17th and early 18th centuries; the second section addresses the importance of the migration phenomenon and governmental measures to contain it in Mexico and the United States; the third describes the characteristics of Mexican migrants' health; finally, the fourth section describes health care policies designed to control migrants in the United States and problematizes the role adopted by the State in the domination of bodies and the migrant population via exclusive health care policies, a strategy that intertwines with market policies. The most important justification for this work involves the national agenda, where the topic of migrants remains a major unresolved issue.

STRATEGIES OF BIOPOWER

The exercise of the State's power manifests via public policies that seek to control individuals and ensure social order. Foucault clearly establishes two aspects of power that have to do with the lives of human beings: first, a power the purpose of which is to "let live or make die" as a faculty of sovereignty; secondly, a reverse power the premise of which is to "make live or let die" and which is identified as biopower (Foucault, 2002: 165). According to Foucault, biopower, which aims to manage and control people, manifests itself in two forms: one aimed at individual control, or anatomo-politics, and another directed toward populations as a whole, biopolitics. Both types of biopower make use of strategies that vary depending on intention. In *Discipline and Punish*, Foucault explains how anatomo-political techniques operate: the methods that "made possible the meticulous control of the operations of the body, which assured the constant subjection of its forces and imposed upon them a relation of docility-utility, might be called 'disciplines'" (Foucault, 2004: 141). The main support or strong arm for said control consists of government policies of public order that operate through legisla-

tion shaped into legal rules of "mandatory" execution. In this context, to understand how power works today, we will address public health care policies aimed at undocumented Mexican migrants and which seek to control these populations of non-U.S. citizens.

If we assume public policies are essentially catered to the neediest population, we will see that, in practice, they are instead meant to protect the least needy by controlling the poorest: interventions in unhealthy workplaces, the application of vaccines, diseases registers, and such measures are intended to control the most deprived social classes (Foucault, 1999b: 384). This strategy corresponds to certain 19th century approaches that are still in use and are a clear example of current biopolitical strategies.

From his first descriptions of biopower, particularly in the biopolitical field, Foucault notes that health becomes a central population control strategy when he explains that great medical advances of the 19th century cannot be dissociated from a notion of diseases and health policy as a political and economic problem posed to communities and requiring global solutions (Foucault, 1999a: 328). When disease is considered a political and economic problem, the responses must be global (i.e. of biopolitical order) insofar as they are directly related to people's lives.

Biopower would not be possible if progress in medicine and biology had not laid its foundation via the implementation of public schemes or strategies to order life—e.g., the isolation of contagious patients with illnesses such as plague or smallpox, which could wipe out entire populations, or genetic pathologies that could be transmitted from parents to children (the essential foundation for eugenics), and the building of cemeteries as zones of environmental pollution. However, the most important instrument for the birth of biopolitics was the quantification of births, illnesses, deaths, etc.; statistical data manifest aspects relating to society as a whole (Foucault, 2001: 223). In truth, the interest of public policy is not to provide benefits to the general population but to act selectively. Historically, biopolitical strategies have tended to protect the most powerful classes, even while risking "minor interest" groups; that is the paradox. Thus, for example, the U.S. government implements (biopolitical) public policies that will certainly benefit U.S.

citizens even though they affect immigrants; such is the case of the health reform approved in March 2010.

In addition to the exclusion of non-citizens, exploitation is yet another factor against migrants, who are employed in less desirable, more dangerous and lesser-paid jobs (Delgado, Márquez and Rodríguez, 2009; Levine, 2006). The most notorious effect of the current biopolitical strategy against migrants in the United States involves labor exploitation, denial of human rights and a kind of control that ensures productivity and obedience. This has its consequences, since those excluded from health services may not remain healthy, least of all given the type of jobs they do. It would be convenient to reconsider such strategies because, in the long run, when workers get older and are sick more often, the results will be counterproductive: less labor productivity, more absences due to illness and, consequently, reduced performance.

Given this scenario, it is imperative that we review bilateral agendas and restructure policies targeting migrants to ensure they are no longer exploited and are given access to a healthy and dignified life. However, given current political trends, this suggestion appears something of a dream, for the most severe measures to prevent migrant access to the United States are already in place. This increase of biopolitical strategies has gotten to the point of eliminating (a seemingly appropriate term) migrants once they are too ill to be useful rather than provide them with the means necessary for their recovery. This is done through a program or, rather, a biopolicy known as the "repatriation of sick citizens"; that is, migrants lacking access to U.S. health services are sent back to Mexico, a measure that denotes the lack of interest both U.S. and Mexican authorities have for Mexican migrants. It also differs from the public U.S. government statement that the large number of Mexicans working in the United States constitutes a unique contribution to the economic development and the social and cultural life in that country (SSA, 2010, 2008: 61). In the end, both strategies are consistent with U.S. goals.

According to Heredia (2011): "the United States has tried to cope with migration through a domestic legislation that does not engage in any sort of discussion (let alone some kind of negotiation), although this is an issue with multiple transnational aspects." Mexico has gone about

things in an opposite way for, until the 1990s, the country handled its relationship with the United States via the "non-policy policy" (Castillo, 2010; Urdanivia, 2011; Heredia, 2011). Durand posits that the Mexican non-policy policy remains active (Durand, 2011); the lack of interest both countries display toward migrants is so obvious they do not mind creating public strategies in their favor because they know these explicit proposals will not be put into practice. This is the case with several national and binational health programs which, coincidentally, tend to delegate health care to the migrants themselves, a strategy the World Health Organization (WHO) designates as self-care for the prevention of diseases (Ferrer-Lues, 2012).

These facts show how health is used by states as an instrument to manage and control one of the most vulnerable populations for the benefit of those who enjoy greater resources. Another frequent strategy consists of providing care to "those without rights" in the case of, for example, contagious diseases that could kill them. These health services, which even garner applause for public authorities and institutions, are, in fact, meant to avoid contagion across the larger population and control the sick and their families through subtle mechanisms of surveillance. Providing health support to those in need is a daily biopolitical exercise carried out via self-care programs for undocumented migrants such as the Binational Health Week (Semana Binacional de Salud, SBS) and the so-called Health Desks (Ventanillas de Salud, or VS), which respond to a biopolitics of electoral strategy. This strategy is similar to what Foucault called the care of the self: "Permanent medical care is one of the central features of the care of the self. One must become the doctor of oneself" (Foucault, 1999a: 456).

Foucault places the birth of biopower at the dawn of the Industrial Revolution (late 17th and early 18th century), a stage that required a compliant and well prepared workforce. From this moment on, body control technologies and discipline techniques are strengthened in order to mold and build the bodies of workers so that they can fully comply with required tasks while remaining faithful to company rules. This is the heyday of disciplinary practices, not only in industrial enterprises but also in all public spaces (prisons, schools, monasteries, factories, etc.).

Soldier training is a clear example of disciplining rigor:

> ... the soldier has become something that can be made; out of formless clay, an inapt body, the machine required can be constructed; posture is gradually corrected; a calculated constraint runs slowly through each part of the body, mastering it, making it pliable, ready at all times, turning silently into the automatism of habit; in short, one has "got rid of the peasant..." (Foucault, 2002: 139).

To keep the bodies of "servants" (workers) and their families healthy was one of the most important principles of the industry. Fordism or the Keynesian welfare state is doubtlessly a manifestation of this. Foucault (1988: 231) considers that, among all population molding and control strategies, subjectification is the most effective, since it constructs human beings under a social scheme of domination and control using different mechanisms. Mora (2010) agrees with this approach and talks about the use of a discourse without violence that, nevertheless, produces effects on the will of the dominated, and the social construction of individuals demands they surrender to authority, obey and understand such a relationship as natural. The subjectification to which Foucault refers relies on a discourse of "truth," arguing that power is not only repressive—for this way it could hardly sustain itself—but also provides pleasure, produces things, is not limited to saying "no" (Foucault, 2008: 148).

In this sense, this study seeks to clarify the mechanisms used by the Mexican and U.S. governments to exercise institutional biopower (biopolitics) on the bodies of Mexican migrants in the United States, taking off from the idea that power is not only the effect of an authority's excercise but a variety of discourses and practices that converge towards the domination and control of bodies (Foucault, 2002: 114). In the case of migrants, what is at stake is life itself; the reach, or rather, orientation of government-implemented strategies to make them live or let them die uses health as an instrument of political proposal, for politics is a way of exercising power in order to, ultimately, dominate and control the life of social subjects through body and thought using either subtle or coercive techniques (Gil, 2009).

Similar to what occurred with sovereign power, current laws give power the legitimate right to preserve life and promote it, administering, conforming and monitoring it during an entire life span. Politics become biopolitics when the life-death polarity favors the former, generating a dynamics in which politically governed and managed migrants are immersed.

Giorgio Agamben has approached biopolitics from the point of view of the inclusion of biological life in the mechanisms of the State, addressing the very essence of all forms of power in the West. The species and the individual, inasmuch as they are living bodies, become the object of strategies of political power that implement whatever care or exclusion policies are employed by current governments (Agamben, 2010).

Thus, one of the centers of focus for contemporary politics is biopolitics. The State's control over the body of individuals manifests itself, for example, in the banning of abortion, sexual tolerance, euthanasia, new forms of procreation, as well as specific guidelines regarding who has access to health services. In other words, this entails the control of migrants through biological processes.

Individuals must assume that their life is controlled by the State, which provides health services and, at any given time, can arbitrarily remove or restrict them by rule of law. Agamben (2010) explains this kind of control comes from a State of exception that places individuals inside or outside the law; that is what characterizes their access to life. In the case of migrants, access to health is tied to the documents that legally sanction their stay in the United States. Those who do not have such a requirement are "legally" excluded from most of the benefits to which a human being is entitled, including access to health services.

Biopolitics is, then, a mechanism adopted by the State to ensure the control of bodies—not as subjects (a feature of sovereign power) but as citizens without rights. This is a condition shared by over 50% of Mexican migrants in the United States (EMIF, 2011; UC and SSA, 2007: 21); they lack U.S. citizenship despite promptly covering the fees or taxes imposed on all workers in the country.

THE MIGRATION PHENOMENON

Historically, Mexico has been a source of workers seeking better living conditions in the United States. This phenomenon has been studied by many researchers, including Durand, Massey, Delgado, Santibañez, and Tuirán, among others. They all agree that Mexican migration toward the United States is related, in good measure, to economic and wage disparities between Mexico and the United States, not to mention the workforce needs of U.S. entrepreneurs which, as Massey points out (2009), lead to fluctuations regarding surveillance and access to U.S. territory, making it easier or more difficult for migrants to cross the border. When more workforce is needed, the number of migrants—documented or not—increases; the opposite is the case when there is less of a need for workers. Another generally accepted idea among researchers is the lack of rights for migrants in U.S. territory, an issue that is still being discussed by the two countries.

The ups and downs of migration pointed out by Massey have historically characterized Mexican migration to the United States. However, economic worldwide crises during this past decade have had considerable impact on migrant transit and stay, because the United States has adopted more stringent policies in order to avoid more undocumented migrants entering the U.S. labor market. In spite of this, the number of Mexican migrants grew steadily from 2000 until 2007, when it reached the peak of the decade at nearly 12 million (Table 1). This is certainly paradoxical given that, by then, U.S. entrance restrictions had increased as a consequence of the September 11, 2001 attacks.

Table 1
Mexican-born U.S. residents by sex, 2000-2008

Year	Total	Men	Women
2008	11,657,266	6,497,339	5,159,927
2007	11,895,657	6,667,862	5,227,813
2006	11,695,228	6,536,156	5,159,072

2005	11,169,112	6,211,409	4,957,703
2004	10,404,919	5,738,773	4,666,146
2003	10,241,301	5,509,483	4,508,004
2002	10,017,487	5,509,483	4,508,004
2001	9,403,069	5,203,968	4,199,101
2000	9,023,756	4,977,486	4,046,270

Source: INEGI official estimates based on U.S. Census Bureau, American Community Survey (ACS), 2008.

Two other aspects constantly visited upon Mexican migrants are abuse and undesirable jobs. As Levine (2006: 97) points out: "It is not surprising that recent immigrants are employed in the least desirable and lowest paid jobs in the United States which, however, pay much more than what they would earn in countries of origin." Delgado, Márquez and Rodríguez (2009: 41) agree with Levine, stating that "employed Mexican migrants do not have access to a wide range of social services: the vast majority do not have access to social security or public assistance programs." These researcher opinions are corroborated by Cristina Aguilar, Commissioner of the Institute for Mexicans Abroad (Instituto de los Mexicanos en el Exterior, IME):

> From individuals with rights and prerogatives we transform into lawbreakers, the persecuted, objects of crime and hate; workers who are required to pay taxes there, but do not have access to basic health services; we do not have the same access to all educational levels, or equitable wages. How paradoxical: we can buy cars, but we cannot have driver's licenses; we can have a tax file number to pay taxes, but we cannot have a social security number which will give us access to full benefits (Aguilar, 2010: 2).

Durand goes a bit further and states that the Mexican strategy known as "non-policy policy," which consists of turning a blind eye to this kind of problems, is a hand-washing policy. After all, it is in the "national interest" that Mexicans seek opportunities abroad, providing an "escape valve" for economic, political and social problems in the country (Du-

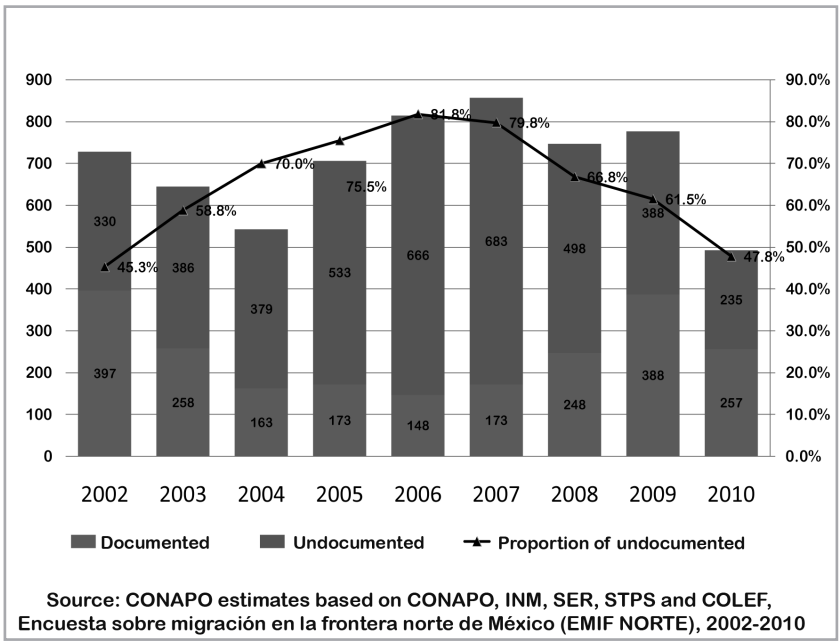
rand, 2011). The U.S. response is similar, since the prevailing laws are their own and, as stated by Massey (2009): "history confirms that the migration process between Mexico and United States has been forged by the unilateral policies of the United States."

Coupled with this age-old issue, the September 11, 2001 attacks evidenced, as far as the U.S. government is concerned, a need for legislation on the subject: more and more states are creating their own laws regardless of the federal government, and the "norm" seems to be the criminalization of Mexican migrants. Discontent among some U.S. citizens is such, that "throughout the decade, states have sought to make their own immigration policies. Only in 2010, state legislatures considered more than 1,500 initiatives related to migration" (De los Ríos, 2011).

However, all these mechanisms had proved insufficient to contain the flood of undocumented Mexicans in search of the "American dream" until 2008, the year in which emigration decreased significantly, even though it has not yet come to a halt (Massey, 2009).

It is clear that the most affected migrant population is that of undocumented workers; however, these are the ones who have proportionally increased over the last decade. Figure 1 shows that, barring 2004, undocumented Mexican migration increased almost systematically from 2002 to 2007, going from 330 to 683 thousand. The opposite happened with legal migrants who fell from 397 thousand in 2002 to 148 thousand in 2006. These data show that, in one way or another (legal or undocumented), migrants continue traveling to the United States and that the way they enter U.S. territory is a result of a reduction in the number of legal permits. It also shows a noticeable decrease of undocumented migration starting in 2008, with 2010 being the year with the least number of people trying to cross the border without documents.

Figure 1.
Mexico-United States labor migration flows, total and undocumented, 2002-2010



Source: CONAPO estimates based on CONAPO, INM, SER, STPS and COLEF, Encuesta sobre migración en la frontera norte de México (EMIF NORTE), 2002-2010

Another aspect that cannot be ignored is the remittances these workers send to Mexico. In 2007, the Inter-American Development Bank (IDB) estimated remittance flow to Latin America at 63 billion USD, of which one third corresponded to Mexico (IDB, 2010). Certainly, these remittances aid in the survival of a large number of Mexican families and the economy of various regions. It follows that policies in this regard are permissive, tolerant, and that none of the involved governments seek to address the underlying problem, because this would entail legal recognition and acceptance, questioning the way migrants are treated in the United States. This is not possible given the power asymmetries between the nations.

MIGRANT HEALTH

Undocumented migration to the United States implies de facto exclusion for not being a citizen of that country. Among other things, undocumented immigrants have no access to health services, an indispensable element for them given health is their main asset. "For those whose only means of subsistence is physical and intellectual workforce, health status is the only reserve, their sole capital" (Miglionico, 2006: 15). The good health of migrants is an employment prerequisite and guarantees the possibility of being hired and incorporated into the U.S. economy under its rules and conditions, which are generally unfavorable for migrant workers.

In this regard, it is worth mentioning that the Mexican migrants who leave their hometowns to work in the United States are, generally, young and healthy people (UC, 2007: 13). This agrees with data that show that most of the illnesses that affect the Mexican migrant population (Table 2) are mostly "benign" and effectively treated in a short span of time. The exceptions are arterial hypertension and diabetes mellitus, which occupy places 7 and 9, respectively, and are not benign, but can be treated effectively with a timely diganosis and do not lead to complications in most cases. Table 3 shows the most common causes of illness among Latino migrants in United States and, as can be seen, most of these conditions require long treatments or surgery, as well as frequent hospitalization. These contrasting pathological aspects among original migrant populations and those already in the United States are probably due to changes in lifestyles, the work they do and, of course, a certain carelessness regarding timely prevention and attention given lack of available health services, which more than 55% of migrants cannot access (EMIF, 2011; UC and SSA, 2008: 21).

Table 2
The ten leading causes of morbidity in Mexico 2008

Frequency	Cause of morbidity
1	Acute respiratory infections
2	Intestinal infections by other organisms and ill-defined ones
3	Urinary tract infections
4	Ulcers, gastritis and duodenitis
5	Otitis media
6	Intestinal amoebiasis
7	Hypertension
8	Gingivitis and periodontal disease
9	Noninsulin-dependent diabetes (type 2)
10	Other helminthiasis

Source: SSA, 2008.

Table 3
The ten leading causes of morbidity in the United States

Frequency	Cause of morbidity
1	Diabetes
2	Obesity
3	Hypertension
4	Tuberculosis
5	Stress-depression
6	Cervical cancer
7	Breast cancer
8	Work-related illnesses
9	Prostate cancer
10	AIDS

Source: SSA (2008:27)

With such high rates of unprotected health among Mexican migrants in the United States, it is essential that the involved governments, especially the Mexican, promote alternatives that will allow these people to at least attend private medical consultation without risking deportation, one of the greatest fears of undocumented migrants. In addition, this would facilitate timely assistance in health centers for prompt treatment of potentially serious problems. So far and given the lack of support, the most common alternatives are home remedies, self-medication, telephone calls to family members for advice, or travel to the nearest border Mexican towns in search of medical attention, among others (Nigenda, 2009).

The living and health conditions to which undocumented Mexican migrants in the United States are subjected are protected by the laws of the country in an exercise of biopower (access to both health and employment are limited or excluding). As mentioned above, this requires decisive action on the part of the Mexican government to improve migrants' living conditions. The first step in this regard would be to ensure the protection of workers inside the companies in which they work; the second and most important would be the concurrence of bilateral agreements between the U.S. and Mexican governments in order to implement the necessary strategies to meet the most urgent health demands. So far and as has been mentioned, neither has responded with substantive changes. The Mexican government made overtures during the presidential term of Vicente Fox (2000-2006), but the binational agreements were not sealed, leaving only good intentions. The Joint Statement on the Health of Migrants between the Secretariat of Health of Mexico and the U.S. Department of Health and Human Services (HHS) is the most emblematic example: in spite of being signed by the highest health authorities of both countries, the results were minimal.

Some U.S. citizens think it normal that migrants are not entitled to health services because they are a drain on the country's economy, and idea that has been disproved (Heredia, 2011; Pérez, 2008) by demonstrating that the contributions made by undocumented migrants are greater than the benefits they receive. The empire of biopower, backed by government policies, will hardly change its strategy regarding Mexican migrants if the current scheme brings the desired results.

Given these kinds of experiences and the background of the Bracero program, Durand suggests that new bilateral agreements should demand that migrant wages in the host country should be similar to those received by resident citizens; they should also receive medical insurance and insurance against unemployment, among other guarantees. The Bracero program, he states, shows that the corruption of Mexican authorities hampered some agreements with United States (Durand, 2007).

HEALTH CARE POLICIES AND BIOPOWER

After almost 150 years of bilateral relationship and an equally lengthy period of migration, Mexico and United States have yet to agree on a policy that ushers in dignified treatment for Mexican migrants who, under the tacit consent of both governments, cross the border to work in U.S. territory. However, binational convenience (the Mexican "non-policy policy" and U.S. one-sided and non-negotiable migration policies) has led to fatal results. It was not until 1961 that the first steps toward the construction of a formal relationship via inter-parliamentary meetings between national legislative representatives were taken. In 1981, the U.S.-Mexico Binational Commission (BNC) was founded; originally, it only included the departments of Foreign Affairs, Commerce and Finance; in 1989, the departments of State and Health were added (Becerra, 2004). The time of formal interaction has been short—some 20 years—and this partially justifies the lack of agreements in the area of migration. However, what is more alarming is that, despite the clarity and urgency of the problem, proposals are quite limited or are meant for other purposes.

One could certainly argue there are several prevention-oriented health programs for Mexican migrants in the United States. But, since March 2010, all access to health services by non-citizens was eliminated under the new U.S. health law. This requires that all citizens be registered in the health system at the same time that it bars undocumented migrants and legal ones with less than five years' stay from accessing it (Bossert, 2010 and Observatorio de la migración, 2010).

The segregation of the undocumented population is an example of biopolitical strategies that seek to control and exploit migrants for the

benefit of U.S. interests. It is a practice that Agamben (2012) describes as a "bare life," or reducing life to its wild state, especially from the perspective of political and social life. This, however, can be changed given that the freedom of migrants, a necessary element for the practice of biopower, is not entirely limited (Foucault, 1988: 238), even when their vulnerability limits their breadth of action and reduces their ability to respond to any "hope" that the Mexican authorities will do something for them. They also have the alternative of returning to Mexican territory, which several thousand have done since 2008.

The issuance of this U.S. law, the full implementation of which will culminate in 2019, reduces the possibility of creating health programs targeted at Mexican migrants living in the United States; extant ones, frankly, have served as political showcases and brought no real benefits since, strictly speaking, only two of them have a direct effect on this community (SBS and VS). Moreover, the program for the repatriation of the sick is not useful in the United States.

There are eight current, though not properly implemented, health programs: the Joint Declaration (DC), 2000; California–Mexico Health Initiative (ISMECAL), 2001; Binational Health Week (SBS), 2001; Leave Healthy, Come Back Healthy (VSRS), 2002; Health Desks (VS), 2002; Repatriation of Sick Conationals (RCE), 2002; and Migrant Health (SM), 2008.

It is striking that there are so many programs targeting the undocumented migrant population, especially considering they have been issued within such a short period. This may be explained by the fact that the first binational agreement of this kind was signed by the health ministers of both countries. This document establishes a series of U.S. commitments to Mexican migrants. The Joint Statement on the Health of Migrants (DC) was reported in the following terms:

> On 22 September 2000, Mexico's Secretary of Health and the United States Secretary of Health and Human Services signed the Joint Declaration on Migrant Health, in which both countries expressed their interest in developing cooperative activities to address the health needs faced by migrants and their families, and pledged to strengthen binational

> collaboration regarding migrant health. This document constitutes a milestone inasmuch as it acknowledges, for the first time, the social and economic importance of Mexican workers in the United States—and I quote: "the significant number of Mexicans working in the United States constitutes a unique contribution to the economic development and social and cultural life of this country." This way, the document explicitly recognizes that the migration process is binational in nature and, for that reason, the responsibility of both countries. (http://www.salud-migrante.salud.gob.mx/interior1/declaracion.html)

Even though, in practice, the program did not explore possible bilateral fields of action, it is important to emphasize that the document explicitly recognizes the migration process as binational in nature and, for that reason, makes it the responsibility of both countries, specifically when it comes to the health of those who migrate to the United States. This comprehensive document clearly shows the intent to control these people, from their place of origin, where they are identified, through their whole journey and on to their destination; i.e., extreme care is taken to ensure a "precise selective process" for those who will cross the border. Even though the program was not carried out, it influenced the creation of other migrant health care programs such as ISMECAL, SBS, VSRS, VS, RCE and SM; all of them have elements of the DC, which reveals the evident U.S. interest, even if VSRS, VS, RCE and SM are, in fact, Mexican. This condition gives sustenance to the negligible practical results of such programs, which is consistent with the lack of agreements between governments.

Each program has truly interesting proposals. VSRS, for example, offers health support for migrants in places of origin, transit and destination; VS provides information on hospitals or health centers open to them where costs are lower and their immigration status will not be reported. SBS is, apparently, the program with the widest dissemination since, from the very beginning, it focused on the state of California and some Mexican border towns; to this date, it is known as the Health Initiative of the Americas, since it now encompasses the whole United States, Mexico, Canada, and several countries of Central America.

The SBS format is of two types: a purely political one, known as the Policy Forum, and so-called health fairs. The first deals with a variety of topics leaning toward health care for migrants, especially in the United States. It is worth mentioning that, ever since the first SBS meeting (in 2001, in Fresno California), binational health insurance was proposed but has yet not been achieved; even though high-powered political and governmental representatives attend the forum, they evidently do not have the authority to propose and decide what to do in cases such as this. The health fairs offer migrants health services such as tests, vaccines, dental checkups, health promotion, condoms, etc. All of these are free; however, there is a risk that the information will be is used to unearth "inconvenient" aspects, e.g., if a person is in good health or could be suffering from any disease or condition of interest to public health, such as tuberculosis, HIV/AIDS, etc. Health promotion actions can also be used as biopolitical strategies to control people, making them responsible for their illness or health. And all these actions can be considered of biopolitical order because they are legally sanctioned.

It is evident that if migrants are young and healthy they will have a chance of entering the United States legally, even in undocumented fashion, because this is ultimately convenient: the binational "investment" is minimal and the profit high. As this population gets older, disease becomes a more likely event and, unfortunately, the most serious diseases tend to occur later in life. Old age and disease are, apparently, the main point of contention between the Mexican and U.S. governments. It has been mentioned that, generally speaking, migrants benefit both countries; this ignores the fact that, before they reach the United States, migrants have already required family care and governmental support to ensure proper development and growth. The United States receives them ready for work; it would seem logical that the country for which they work and to which they entrust their health would provide them with the necessary support to achieve a dignified life; but support is minimal, and as mentioned above, Mexico, through the RCE program, has decided to take care of them when they are ill and are no longer productive or, in a nutshell, no longer profitable to the United States.

It would be interesting to learn more about this program, since not much is known about it and the implications for the country and migrants could be fatal. It is an irrefutable example of biopolitics working in the interest of power: on the one hand, the laws exclude migrants and, on the other, the implementation of such a program liberates power from its responsibility toward these people. This biopolitical strategy agrees with Foucault's idea of biopower as the managing and very precise controlling of life (Foucault, 2002: 165).

The counterpart to the above proposals is the U.S. health care bill approved in March 2010. This progressive unilateral policy will be finalized in 2019. It intends to register the bulk of U.S. citizens under governmental health insurance, leaving out all undocumented immigrants and even documented ones with less than 5 years of residence in the United States. In addition, it does not allow these two groups to acquire private medical insurance. This reform has reached its second year and we do not know the conditions in which migrants without rights are faring, but more than one researcher indicates we should expect massive deportations once the "grace period" is over (2019). We return, then, to biopolitical strategies: rather than making migrants live, power is managing them to extract the greatest profit and eventually extradite them. There are still seven years left and things are likely to change during that time. We hope they do not cause Mexican migrants further harm.

Finally, it is difficult to understand why, considering so many people are affected by this law (6.5 million in 2010; Conapo, 2011: 251), none of the two governments involved are clearing paths to a solution.

FINAL COMMENTS

Regarding power's mechanisms of action, Foucault says there is not just one acting power but several at once; he also says power is not merely repressive, it also provides benefits. These "axioms" indicate that the ways through which the biopolitical exercise can be conducted are so vast and unlimited that they practically do not leave a margin in which a common citizen can remain exempt from any of these strategies. Our topic—the health of undocumented Mexican migrants living in the

United States—is particularly rife with biopolitical action given the vulnerability of these citizens due to their undocumented status.

Undocumented migrants leave their places of origin knowing their living conditions will be different and they will have to obey all kinds of orders (they leave their homes following the instructions of *polleros*); they are warned that if they do not obey they will not only lose the chance of crossing the border, but their lives will be in danger. If, on the other hand, "they are compliant," they will reach the United States and get a coveted job that will cover their needs. These migrant experiences highlight two facets of biopower: the negative one, concurrent with obedience and ill-treatment, and the positive one—crossing the border and getting the desired job. This is the common pathway of biopower, the first instance of the migrant experience. The mechanisms through which biopolitical health strategies are incorporated into these populations constitute the culmination of this exercise. Health support and preventive care (e.g., vaccines, laboratory tests, early disease detection and the promotion of hygienic measures) are not for free. Personal well-being is not the main goal; first and foremost, it benefits the United States by "avoiding" possible contagion from "non-citizens." These actions exemplify the biopolitical measures to which Mexican migrants are subjected. Another biopolitical strategy, derived from the lack of support regarding sick care, is self-care: i.e., making migrants responsible for their own health; it is their obligation to take care of themselves and stay healthy.

Here we have shown how the discourse of power changes according to its interests; real needs or the health of migrants do not matter much. What is important are the profits obtained from their administration and control. The evidence is clear: there is a switch from a biopolitical strategy that entails more costs and greater commitments (preventive and curative care) to another (self-care) that renders the same profits but costs less.

This is nothing new, but it should be mentioned that U.S. interests will overwrite any action taken by the Mexican government; biopower remains valid inasmuch as it establishes its "dominion" over the Mexican government, even if this is ultimately for mutual convenience.

REFERENCES

AGAMBEN, Giorgio (2010), *Homo Sacer. El poder soberano y la nuda vida*, Valencia, Pre-Textos, available at http://www.slideshare.net/Brirosa/conceptos-homo-sacer-y-nuda-vida-en-g-agamben/download (16/05/2012).

AGUILAR, Cristina (2010), "Mensaje de la Comisión de Salud del IME presentado en la Inauguración de la XVI Reunión Plenaria del Consejo Consultivo del Instituto, en la Ciudad de Tuxtla Gutiérrez, Chiapas, el jueves 4 de noviembre de 2010," available at http://www.ime.gob.mx/ime2/images/ccime/discursos/xvi_dis_cristina_aguilar.pdf (20/01/2012).

BECERRA Gelover, Alejandro (2004), "Mecanismos de comunicación intergubernamental entre México y Estados Unidos," in *El Cotidiano*, vol. 20, no. 127, Mexico, UAM–Azcapotzalco.

BOSSERT, Thomas (2010), "La Reforma de la Salud en Estados Unidos: Acuerdos Imperfectos," in *Observatorio de Políticas Públicas*, year 5, no. 8, Cali, Facultad de Ciencias Administrativas y Económicas, Universidad ICESI.

CASTILLO, Manuel Ángel (2010), "Los derechos sociales de los migrantes," in Paula Leite and Silvia E. Giorguli (coords.), *Reflexiones en torno a la emigración mexicana como objeto de políticas públicas*, Mexico, Conapo.

COMISIÓN Técnica de las EMIF (2011), *Situación de la emigración mexicana y la migración de tránsito irregular en México*, Mexico, Conapo, INM, SRE, STPS, Colef.

DELGADO Wise, Raúl, Humberto Márquez Covarrubias and Héctor Rodríguez Ramírez (2009), "Seis tesis para desmitificar el nexo entre migración y desarrollo," in *Migración y Desarrollo*, no. 12, Zacatecas, RIMD–UAZ.

DURAND, Jorge (2011), "Migración internacional y políticas públicas: inercias y desafíos," in *Ibero, Revista de la Universidad Iberoamericana*, year III, no. 14, Mexico, Universidad Iberoamericana.

_____, (2007), "El Programa Bracero (1942–1964). Un balance crítico," in *Migración y Desarrollo*, no. 9, Zacatecas, RIMD–UAZ.

Ferrer Lues, Marcela (2012), "Reflexiones sobre la concepción de la salud como responsabilidad individual: Construyendo Bioética en Salud Pública," in Francisco Javier León Correa (coord.), *Bioética y sociedad en Latinoamérica*, Santiago de Chile, Fundación Interamericana Ciencia y Vida.

Foucault, Michel (2008), *Un diálogo sobre el poder y otras conversaciones*, Madrid, Filosofía Alianza/ Materiales.

_____, (2004), *Vigilar y castigar: nacimiento de la prisión*, Buenos Aires, Siglo XXI.

_____, (2002), *Historia de la sexualidad 1. La voluntad del saber*, Mexico, Siglo XXI.

_____, (2001), *Defender la sociedad*, Buenos Aires, Fondo de Cultura Económica.

_____, (1999a), "La política de salud en el siglo XVIII," en *Estrategias de poder, Obras esenciales*, vol. II, Barcelona, Siglo XXI.

_____, (1999b), "Las mallas del poder," in *Estética,* ética *y hermenéutica, Obras esenciales*, vol. III, Barcelona, Siglo XXI.

_____, (1988), "El sujeto y el poder," in Hubert L. Dreyfus and Paul Rabinow, *Michel Foucault: Más allá del estructuralismo y la hermenéutica*, México, UNAM.

García Canal, María Inés (2005), "Poder, violencia y palabra," in *Tramas. Subjetividad y Nuevas Tecnologías*, no. 25, Mexico, UAM–Xochimilco.

Gil, Marta (2009), "Poder, verdad y normalidad: genealogía del hombre moderno a través de la lectura de M. Foucault," in Cuaderno de Materiales, no. 21, Madrid.

Hall, Joan (2010), *Diez años de innovación en remesas: lecciones aprendidas y modelos para el futuro. Evaluación independiente de la cartera de proyectos en remesas del Fondo Multilateral de Inversiones, miembro del grupo BID. Proyectos, estudios y actividades de diseminación del Fondo Multilateral de Inversiones del 2000–2009*, Washington, Fomin, BID.

Heredia Zubieta, Carlos (2011), "La migración mexicana y el debate en Estados Unidos a la sombra del Tea Party," in *Nueva Sociedad*, no. 233, Buenos Aires, Fundación Friedrich Ebert.

LEVINE, Elaine (2006), "Condiciones laborales y salariales para migrantes mexicanos en Estados Unidos," in Melgar Mario (coord.), *Migración a Estados Unidos, más allá de los números*, Mexico, UNAM.

MASSEY, Douglas S., Karen A. Pren and Jorge Durand (2009), "Nuevos escenarios de la migración México-Estados Unidos. Las consecuencias de la guerra antiinmigrante," in *Papeles de Población*, vol. 15, no. 61, Mexico, UAEM.

MIGLIONICO, Caino Walter (2006), *Salud y trabajo, guía para la acción sindical*, available at http://www.aebu.org.uy/doc_salud_02.pdf, (4/12/2006).

MORA Rodríguez, Luis Adrián (2010), "Dominación y corporalidad: técnicas de gobierno en la conquista americana," in *Tabula Rasa*, no. 12, Bogotá, Universidad Colegio Mayor de Cundinamarca.

NIGENDA, Gustavo *et al.* (2009), "Análisis de las alternativas de los migrantes mexicanos en Estados Unidos de América para atender sus problemas de salud," in *Salud Pública de México*, vol. 51, no. 5, Cuernavaca, Instituto Nacional de Salud Pública.

NOVELO Urdanivia, Federico (2011), "Por una política migratoria integral," in *Rev. Cofactor*; vol. II, no. 3, México, CIEPS, Gobierno del Estado de México.

OBSERVATORIO de la Migración (2010), *La Reforma de salud en Estados Unidos*, available at http://www.observatoriodelamigracion.org/OM/La_reforma_de_salud_en_Estados_Unidos.html, (20/01/2012).

PONCE, Carlos (2012), "Latinos Discriminados en Estados Unidos: la hipocresía de los impuestos sin beneficios," in *Revista Nueva Política*, vol. 2, no. 13, Bogotá, ETM, REDLAD, available at http://twolatinamericas.blogspot.mx/2012/03/latinos-discriminados-en-estados-unidos.html, (2/05/2012).

RÍOS Lozano, Patricia de los (2011), "El papel de los estados en la política migratoria de Estados Unidos," in *Ibero, Revista de la Universidad Iberoamericana*, year III, no. 14, Mexico, Universidad Iberoamericana.

SSA (2008), "Declaración conjunta sobre salud del migrante," Mexico, SSA, Gobierno Federal, available at http://www.saludmigrante.salud.gob.mx/interior1/declaracion.html.

SSA (2002), *Programa de Acción Específico 2007–2012. Vete Sano, Regresa Sano*, Mexico, SSA, Gobierno Federal.

TEJEDA González, José Luis (2011), "Biopolítica, control y dominación," in *Espiral*, vol. XVIII, no. 52, Guadalajara, Universidad de Guadalajara.

UNIVERSIDAD de California and SSA (2007), *Migración, salud y trabajo: datos frente a los mitos*, Mexico, Regents of the University of California, SSA.