Health Care in Mexico

By Dr. Abdo Jurjus
Lebanese Health Society

The Mexican health care system developed and evolved under the sponsorship of the state. Although it cannot be defined at any time ad a democratic system, in the 1930's, when the system was initially organized, it resembled that form. This is the one of the main features to have in mind in comparing the Mexican system with other health care systems. To assess the development of the Mexican health care system, we will focus on the relation ship of the system with the state in the past and nowadays, its organization, and the relationship between the state and the development of the health professions (particularly the medical profession) in the country.

Colonial Period

During the colonial period (1521-1821), medical care and indigent care were carried out mainly by the Catholic Church; however, some communities also provided care sponsored by the vice regal government or by private entrepreneurs. The Christian ideology of helping one's neighbor and giving charity to poor led to the creation of nursing homes, hospitals, and houses for the care of the needy.

Independence Period

After the achievement of the independence in 1821, the Christian concept of charity was replaced nominally, but never substantially, by the liberal idea of public welfare. This meant that the state would conduct some philanthropic medical care activities, chiefly through the hospital, but without a legislative mandate to carry them out. As in previous years, private solo practice was dominant. Private assistance was still provided, but was less important than during colonial times.

Preindustrial Era

After a few years, medical care and assistance were neglected and for more than five decades did not receive attention from the state. In the last 20 years of the nineteenth century and the first decade of the twentieth, under the dictatorship of Porfirio Diaz (overthrown by the Revolution of 1910 to 1917), sanitation and welfare programs were reactivated, but on the same inadequate basis.

The new regimes, after the Revolution did not change the organization and institutions of health and public welfare; private assistance went on much as before. In the 1930s, during the Lazaro Cardenas administration (1934-40), the concept of welfare experienced significant changes and became "social assistance" as a compulsory activity of the state. This implied the end of the philanthropic state, and the idea of health care as a right of the entire population began to be discussed. As a consequence, the Secreteria de Asistencia Publica (Ministry of Public Assistance) was created in 1937.

The theoretical purpose of this institution was to deliver medical care to the whole population, a goal that has not been fulfilled up the present time. Another public organization, the Departamento de Salubridad (Department of Sanitation), dealt with problems of epidemics, sewage, portable water and basic sanitation. In early 1940's the Departmento of Salubridad and the Secretaria de Asistencia Publica merged to form a new institution, the Secretaria de Salubridad y Asistencia (Ministry of Sanitation and Assistance), which has since played the role of the ministry of health. Traditionally concentrated in the cities, the health and medical care services started, during the late 1930s, to be extended to the rural areas.

The Cardenas administration stressed a policy of coverage of the peasants through a branch of the Secretaria de Asistencia Publica, the Servicios Medicao-sanitarios Ejidales (Medical and Sanitary Services for the Peasants), which administred the social service required of medical students in their last year. The Servicios Medico-sanitarios Ejidales became, in 1941, the Servicios Rurales Cooperativos, which in the late 1950s changed its name to Servicios Coordinados de Salubridad y Asistancia, but it combines the federal and state levels of decision making. It is concerned with the administration of ambulatory care facilities in the rural areas as well as the organization of some public hospitals in various states and is in charge of the public health services in every state.

Nineteenth Century: Industrial Era

In the 1940s, Mexico changed its model of economic development. The former economy, based on the export of raw materials, became increasingly industrialized. This change and the protectionism of the state with regard to industrial capital had a corresponding effect in the health field. The public resources devoted to health care were concentrated on the production of qualified manpower. At the same time, the unionized industrial workers formulated demands for medical care that were recognized very soon by the ruling class. As a consequence, the Instituto Mexicano del Seguro Social (Mexican Institute of Social Security) was created in 1943. This agency was organized to provide medical care in its own facilities with salaried personnel to the most organized and productive sector for the working people of Mexico: the industrial workers of the cities. It was also in charge of the pension funds for industrial workers.

More than 15 years later the story was repeated for government workers. In 1960, the Instituto de Seguridad y Servicos Sociales para los Trabajadores del Estados (ISSSTE) (Institute of Social Security and Services for State Workers) was created, with the obligation of providing medical care to government workers. Similar and separate medical care programs were provided for the railroad workers, the oil workers, the electrical workers and others.

Twenty Century: Multiple Supporting Funds

The enormous number of public institutions related to health care was further increased during the 1960s with the emergence of the Instituto Nacional de Proteccion a la Infancia (National Institute for the Protection of Infancy), which also provided medical care. This institution merged with another public organization, the Institucion Mexicana de Asistencia a la Ninez (Mexican Institution for Childhood Care), created in 1970 to deliver maternal and child health care. The new organization that now includes these two in the Sistema Nacional para el Desarrollo Integral de la Familia (national System for Comprehensive Family Development), created in 1977.

The basic trends just presented resulted in a multiplicity of institutions that characterize the Mexican health care system up the present time. But to have a complete picture of the present situation, it must be noted that private individual and group practice in the way in which a minority of the population-individuals with high socioeconomic status-receive medical care.

The Reform Attempt:

In the 1980s new reformist effort attempted to solve the accumulate problem of disorderly expansion in medical care in both the public and the private sector. The origin of this initative was the creation of a transitory planning body called the national Health Services Coordination during Presidet Josae Lopez Portillo's administration (1976-82). A prestigious physician Dr. Guillermo Soboron, was named the director of the Coordination, and he set a team to work on the creation of a national health system. This new system would address the internal division in the health care sector, as well as the problem of lack of access to health care.

The aims of the reform were to integrate the health sector and to position the secretary of health as the indisputable head of the sector. This modernization effort was faced with resistance from the Mexican Social Security Institute, as well as the main unions in the country. Nevertheless, the 1982-88 period was critical for the present structure of the health care system; it set the legal foundation for the current reform, in particular legal recognition of the private sector as a health sector component.

As this implies, until recently the state had absolute control over the health care sector. This was done through the medical services of social security institutions and Ministry of health (SSA). Thus the state contracted most of the physicians active in the medical labor market thanks to the corporatist nature of the Mexican state and its success in co-opting the medical elite into public health care institutions.

During the 1988-94 presidential period there was a strong effort in different sectors of the economy to reduce the role of the state, and the result was the erosion of the Mexican corporatist state. Although the effects were felt more in the political spectrum, creating power vacuums and an identity crisis in the Mexican government, they also has been a movement sponsored by international agencies to privatize the public health care institutions with the aim of creating a "pluralistic" system similar to the one found in the United States.

Mexico fosters three unequal, yet parallel systems of health care. There six government-run social security institutions that provide care for approximately 50 million of Mexico's gainfully employed. The uninsured poor, comprised by about 40 million Mexicans, receive limited health-care benefits administered by the Ministry of Health of Mexico. The private sector, which represents 3 million Mexicans, is comprised of individuals whose health-care funding is met through private insurance carriers.

Social Security

The largest and most notable security organization is the Mexican Social Security Institute or IMSS. The IMSS is available for foreigners residing in Mexico and is funded by contributions from employers, beneficiaries, and the Mexican Government.

Hospitals and clinics that provide medical care for Social

Security recipients vary in quality. While major urban institutions may provide adequate to advanced tertiary care, rural hospitals often have outdated equipment, long waits, and inadequate staffing. In the IMSS system, you cannot choose your primary care provider. Therefore, your access to care and hospitals is regulated by your assigned physician.

Many of the doctors see patients in an IMSS clinic as well as private practice setting. One way to circumvent the IMSS referral process is to see a doctor with IMSS privileges in private practice. Then, have that doctor refer you the best IMSS facility for care (through the IMSS system). Social Security costs for medical care and prescription drugs are far lower than in the United States.

The Private Sector

In general, private medical care in Mexico is preferred: up to 25% of patients with Social Security benefits or no coverage at all prefer to pay out of pocket for private care. Since health care in Mexico is generally much less expensive than in North America, cash payment is still an affordable option. The cost for a general medical consultation may begin as low as US $20 (cost rise in major cities and tourist destinations). Very few Mexicans have private health insurance but this sector is growing.

Many private hospitals in Guadalajara, Monterrey and Mexico City offer some of the most advanced tertiary care centers in the world. Tertiary care is advanced care (i.e., cardiovascular, evaluation and surgery, neurological evaluation and surgery, orthopedic surgery, hemodialysis, organ transplant among others) that requires highly specialized skills, technology and support services. Most of the doctors in these hospitals have had excellent Mexican medical education, and may have trained abroad in Europe or North America.

There are also very good medical centers in many smaller cities frequented by tourists. Private "hospitals" or clinics in rural destinations tend to be owned by group of local physicians with varying levels of training. Their facilities and technology are typically outdated, but are adequate to manage minor illnesses.

Ministry of Health

Nearly half of Mexico's 100 million inhabitants have no health insurance benefits at all. Their preventive care is limited to vaccinations and oral rehydration programs for children. Care in this sector is extremely limited. For example, infant mortality is ten times higher than in the parallel private sector. Red Cross or Cruz Roja hospitals service the poor and are accessible to anyone in Mexico regardless of their ability to pay.

Health

Aggregate health statistics have improved greatly since the 1970s. However, Mexico lags well behind other OECD countries in health status and health care availability. Total health care spending accounted for 6.4% of gross domestic product (GDP) in 2005; per capita spending on health care was US $675 (adjusted for purchasing power parity) - about a quarter of the OECD average. During 2005, 45.5% of health spending was paid from public sources - comparable to the share of public spending in the United States but significantly below the OECD average. Private financing in Mexico is almost entirely in the form of out-of-pocket payments, as only 3.1% of total expenditures on health are funded through private health insurance. In 2005 Mexico had 1.8 doctors and 2.2 nurses per 1000 population, a significant increase in health care personnel over the previous decade but again below the OECD averages for these indicators. The mortality rate of children younger than five years was 17 per 1000 live births in 2005. Ninety-seven percent of the population had direct access to potable water and 80% to sanitation. In 2005 the incidence of human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) among persons aged 15 to 49 was 0.3 percent.

Diabète : comment le prévenir ?

Les sucres, c'est important pour avoir de l'énergie. Mais il faut essayer de privilégier ceux que le corps absorbe lentement, c'est-à-dire ceux qui ont un index glycémique (IG) faible.

Les sucres lents à index faible sont les légumineuses : lentilles, haricots secs, fèves, pois chiches, soja et les fibres en général. Les pâtes, les féculents (pain, riz, pommes de terre) ont un index plus élevé. Pour ralentir l'arrivée de leur sucre dans le sang, une solution: les accompagner d'aliments contenant des fibres (légumes verts) ou des protéines (viandes, poissons, laitages).

Les graisses, avec modération

L'important est de manger moins gras et de privilégier les graisses non saturées. Pour cela, les recommandations sont les mêmes pour tous : consommer le beurre cru et en faible quantité, utiliser de l'huile d'olive ou des mélanges d'huiles végétales pour la cuisine et les assaisonnements. Viandes blanches et poissons seront favorisés alors que l'on diminuera le fromage et les produits laitiers, riche en graisses.

Si vous mangez des tartines beurrées au petit-déjeuner, essayez de ne pas craquer pour une crème dessert au repas suivant, et de ne pas noyer vos crudités dans l'huile.

Si vous aimez goûter à des saveurs exotiques, un menu japonais de temps en temps peut être intéressant : sushis et sashimis apportent des protéines et les graisses des poissons abaissent l'index glycémique du riz blanc. Le tofu, riche en protéines végétales et en lipides saturés, est aussi excellent. En revanche, doucement avec les sauces, car elles sont souvent très salées.

Les desserts, vous y avez droit

Bien sûr, rien ne vaut les fruits. Mais on a le droit d'être gourmand de temps en temps.