

# Crisis, Living Conditions and Health in Mexico: New Challenges for Social Policy

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## **The Latin American context**

Latin American economic indicators – growth rates, levels of employment and salary, and income distribution – paint a picture of a continent with high levels of poverty and increasing social and economic polarization.<sup>1</sup> According to the Economic Commission for Latin America (ECLA),<sup>2</sup> rates of poverty in Latin America increased from 41 percent in 1980 to 44 percent in 2000. Since the population also increased during this period, the absolute number of poor people grew significantly. World Bank data provides further support for this conclusion. In 1981 36 million people in Latin America survived on one dollar a day or less (extreme poverty); this number increased to 50 million by 2001. The number of Latin Americans surviving on two dollars a day or less grew from 99

million in 1981 to 128 million in 2001. By 2004, nearly 121 million lived below this cut off.<sup>3</sup>

The sustained growth of both poverty and extreme poverty results from unequal access to the benefits of socially generated economic growth. In Latin America, the richest 10 percent of the population receives nearly 50 percent of all income; the poorest 10 percent receives less than 2 percent. Employment statistics also show regression. Rates of unemployment increased from 5 to 11 percent between 1990 and 2003. This situation has grown worse following the 2008 economic crisis. As noted by ECLA:

*...estimated growth rates for the region suggest that unemployment will increase from the projected 7.5% in 2008 to between 7.8 and 8.1%. This reflects the increasing involvement of the labor force in informal employment.<sup>4</sup>*

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The situation is, however, complex and average indicators show important advances in health status. Maternal and infant mortality have decreased with a resultant increase in Latin American life expectancy which reached 70 years in 2000. Nevertheless, by comparing health statistics both within and between nations, we find increasing epidemiological polarization, complexity, and public health regression. Epidemiological polarization refers to the growing increase in the health inequalities between countries, regions, and social groups; it is the most vulnerable populations that experience excess morbidity and mortality from a variety of causes. Complexity refers to the simultaneous presence of “new and old” epidemics. Public health regression is the re-emergence of diseases previously eradicated or under

control.<sup>5</sup> Thus, life expectancy varies from 54 years in Haiti to 79 years in Canada.<sup>6</sup> Infant mortality, a sensitive indicator whose reduction is included in the Millennium Development Goals, had an average value of 24.8 deaths per 1000 live births in 2000. However, national values went from a low of 5.2 in Antigua to a high of 80.3 in Haiti. National statistics showed values ranging from 3.7 deaths per 1000 live births to 133.<sup>6</sup>

### **The crisis and deterioration in living standards in Mexico**

In the last 30 years, Mexico has faced major crises in its political, economic, and social life. These crises have affected living conditions and health. With the implementation in the 1980's of structural adjustment and economic stabilization policies, Mexico saw a rapid growth of poverty accelerating trends toward social polarization and social division.

The current crisis, fueled by deregulation of the global financial markets, only deepens the tendency towards economic stagnation. It has led to an increase in unemployment, worsening income inequalities, and generalized inflation. The increase in food prices, in particular, has made life more difficult for the Mexican population. The crisis has had a palpable and concrete impact on living conditions, health status, and food security for diverse social groups.

The growth of Mexico's Gross Domestic Product decreased from 3.2 percent in 2007 to 1.8 percent in 2007. This was seen in a general decrease in domestic consumption, declining exports, a fall in real wages, and a drop in the amount of money sent back to Mexico by migrant

workers overseas.<sup>4</sup> For the first trimester of 2009, unemployment reached 5.25 percent of the economically active population; this was the second highest rate since 2000.

Between 2006 and 2008, the poorest 20 percent of the population saw their incomes reduced by 7.6 percent while the richest 20 percent increased their income by 0.1 percent. During this period the absolute number of people living in poverty increased dramatically, reversing the trend for the period seen from the early 1990's to the middle of the present decade. While in 2006 around 45 million people lived in conditions of "net poverty" (see box), by 2008 almost half of all Mexicans belonged to this class; this represents an increase of practically 5 percentage points during the biennium. The percentage of people living in nutritional poverty increased from 14 to 18 percent; in absolute terms this corresponded to an increase from 14.4 to 19.5 million people. Basic Needs poverty grew from 21 to 25 percent, corresponding to an increase from 21.7 to 26.8 million people. Thus, the percentage of homes suffering from each of these three forms of poverty increased between 2006 and 2008.<sup>7</sup>

### **Epidemiological complexity**

The deterioration of living conditions and health status are expressed in disparities in the distribution of ill health, one form of epidemiological complexity. Mexico is experiencing an uneven demographic transition with its own aging population. Patterns of morbidity and mortality are not straightforward; the diseases of poverty – infections and nutritional deficiencies – persist alongside those of an aging population (chronic and degenerative diseases), traumatic injuries (both accidental and intentional), mental illness, substance abuse, and nutritional problems. As these problems become more common, we also see new diseases such as HIV/AIDS and new global threats such as H1N1 influenza.

In 2005, life expectancy at birth was 77 years for men and 79 years for women; for the indigenous population, however, life expectancy was only 65 years. Infant mortality for 2005 was relatively low in both Mexico City (DF) and Leon:

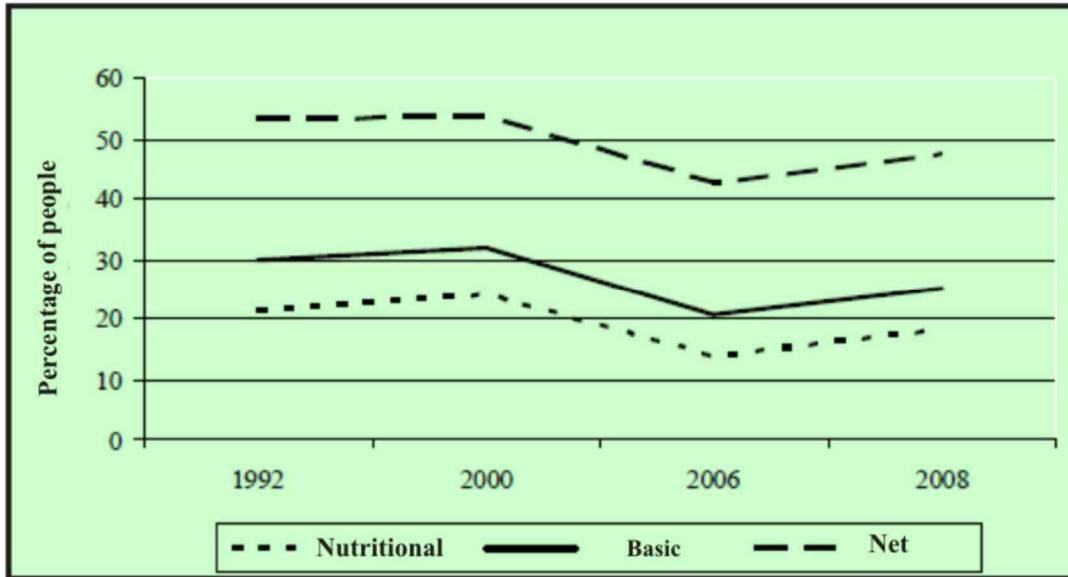
#### **Mexican Definitions of Poverty**

**Pobreza Alimentaria** (Nutritional Poverty): Unable to purchase sufficient food.

**Pobreza de Capacidades**: (Poverty of Basic Needs): Able to purchase food but unable to purchase health or education for all family members.

**Pobreza de Patrimonio** (Net Poverty): Able to purchase food, education, and health but not housing, clothing, transport or other needs.

### Evolution of Poverty by Income Level, 1992-2008



Source: Adapted from Reference 7

sixteen deaths for every 1000 live births. By contrast, in the States of Chiapas, Guerrero, and Oaxaca infant mortality reached 20 death (females) and 25 deaths (males) per 1000 live births. Seventy nine percent of these infantile deaths were considered avoidable. In those municipalities with the lowest scores on the Human Development Index (HDI) [*Indice de Desarrollo Humano (IDH)*], infant mortality reached 32.5 deaths per 1000 live births; in those with the highest HDI scores, there were only 15.8 deaths per 1000 live births.<sup>8</sup>

The 2006 National Health and Nutrition Survey reported national prevalence for short stature of 12.7%, for low weight of 5%, and for low weight for stature of 1.6%.<sup>9</sup> Yet rural areas of southern Mexico have a prevalence of low weight higher than 25 percent. By contrast, in Mexico City and its metropolitan area over 70% of adults and 30% of school age children are obese or overweight.<sup>9</sup> Increasingly, obesity is seen among those groups with most limited resources. And, ironically, these are the same populations where nutritional deficiencies and the diseases of malnutrition are most common, still affecting large numbers of victims.

Nearly a third of deaths occurring in the 100 poorest Mexican municipalities are due to

infections, malnutrition, or reproductive problems. This is similar to national trends 18 years ago and to what happened in Mexico City and Nueva Leon 25 years ago.<sup>8</sup> Life expectancy in these municipalities is 49 years for men and 51 years for women.<sup>8</sup> Health disparities are also seen in maternal mortality. Not only is the national rate of 6.0 deaths per 10,000 live births elevated, but rates in Chiapas, Guerrero, Oaxaca, Nayarit, and Chihuahua are over 8.0 deaths per 10,000 live births. Under-five rates of short stature are likewise higher in the rural areas than in urban ones.<sup>8</sup>

Epidemiologic complexity is also evidenced by the rapid changes in prevalence of certain diseases, among which diabetes mellitus is the prime example. Standardized diabetetic death rates (per 100,000) increased for men from 79.9 deaths in 2000 to 86.1 death in 2005; for women the corresponding figures were 79.9 deaths in 2000 and 89.9 deaths in 2005. Of note, during this period, death rates from coronary artery disease remained stable.<sup>8</sup> The dynamics of the HIV/AIDS epidemic have also undergone important changes. In 2005, HIV/AIDS was the fourth leading cause of death in men between the ages of 25 and 34. By 2006, over 110,000 cases of AIDS had been registered and 182,000

Mexicans were thought to be asymptomatic carriers of the virus. Deaths from HIV/AIDS increased among women from 1997 to 2004 while they declined among men.<sup>8</sup> Mental illness and substance abuse have become important health issues. The 2005 National Survey of Psychiatric Epidemiology found that 9 percent of the population has suffered from depression during their lifetime and 5 percent had been depressed in the previous year. The survey found that 11 percent of male deaths are associated with alcoholism; this proportion varied from a high of 15 percent in Oaxaca to a low of 8.3 percent in Nuevo Leon.<sup>8</sup> It is estimated that half of all mortal vehicular accidents involve alcohol consumption.<sup>8</sup> The 2002 National Addiction Survey found that 3.5 million Mexicans between the ages of 12 and 65 have used drugs; the prevalence in urban areas is twice that of the countryside.<sup>10</sup>

### **Dismantling the public health system**

The Mexican State has eluded its responsibility to guarantee the constitutional right to the protection of health by transferring health care functions to various non-State actors; these include for-profit companies, community organizations, families and individuals. In practice, this process is destroying the institutional base from which to create universal and inclusive health programs.<sup>11,12</sup> Spending on public health has been reduced and the public health care system has been neglected. There are not enough facilities and those that exist are inadequate. Their physical structures are deteriorating and their equipment is obsolete. The analysis of disease causation has been reduced to the most simplistic level.

These actions progressively reduce the capacity of public institutions of social protection to respond to social problems. And it is precisely this reduced capacity that serves as the pretext for further assaults on the public sector by neoliberal technocrats. This situation is highlighted by the reduction of Mexican public health spending which was reduced from 3.7 percent of GDP in 1982 to 2.7 percent in 2007.<sup>13</sup> The 1997 reform meant that the Mexican Social Security Institute (*Instituto Mexicano Seguro Social*, IMSS) saw

cuts in its coverage of maternity and illnesses. It was forced to create economic reserves, limiting its ability to cover deficits in insurance coverage. IMSS now finds itself less able to invest in needed medical infrastructure; it is estimated that 60 billion pesos are needed for infrastructural development. As a consequence of defunding, IMSS medical visits have dropped from 1.2 consults per 1000 insured in 1982 to 0.4 consults in 2006. IMSS hospital beds have decreased from 1.7 per 1000 insured in 1982 to 0.32 in 2006.<sup>4</sup> Of course, important regional differences persist in financing as well as health care service and quality. Per capita public spending on health in 2005 showed marked differences between the states. While the states of Mexico, Michoacán, Puebla, and Chiapas spend between \$1250 and \$1500 per capita on health, in Campeche, Tabasco, and South Baja California per capita expenditures are \$ 3500 and in Mexico City, they reach \$6000. Out of pocket medical costs for the poorest households nearly doubled between 2000 and 2005 going from 8 percent of income to 14 percent. For the richest households out of pocket medical expenses remained stable at 4 percent.<sup>15</sup> Disparities also exist in the availability of resources. Chiapas, Oaxaca, Puebla, Michoacán, Guanajuato, and Zacatecas have between 0.4 and 0.8 doctors per 1000 inhabitants, while Aguascalientes, South Baja California and the Federal District have between 1.6 and 2.7 doctors per 1000 inhabitants. The availability of hospital beds varies from 0.2 to 0.3 per 1000 inhabitants in Guerrero, Oaxaca, Chiapas, and the State of Mexico to between 1.2 and 1.8 per 1000 inhabitants in Mexico City. The proportion of attended childbirths offers remarkable differences between states: Aguascalientes, Colima, and the Federal District reports that 100 percent of births are attended. In the states of Mexico, Guerrero, and Chiapas the proportion is around 50 percent.<sup>15</sup>

### **Closing Reflections**

The nearly three decade long reign of neoliberalism has had a major negative impact on most Mexicans. By degrading the social determinants of health and setting back the goal of social equality it has generated a social and health paradox. Health

problems grow and become more complex while the capacity of the State to solve these problems is progressively diminished. The social institutions that have historically promoted health and equity are being destroyed. The exercise of their right to health protection remains a mirage for an important part of the Mexican population.

In the past few years, poverty, inequality, and unemployment have all increased, damaging the social fabric. The situation presented in this paper forces us to focus on the structural aspects of the Mexican economy. We are challenged to consider social policies from a viewpoint that places the cause of inequality in a system of economic production, consumption, and distribution of wealth. This is not about focused poverty alleviation programs that end up excluding and discriminating against the "taken care of" social groups; these programs only further fragment social cohesion. To present health as a social right starts out from principles of citizenship, recognizes that the guarantee of health is essentially political, and bases its realization on the satisfaction of needs rather than the logic of the market. To make this right a reality requires structural changes in the way Mexico produces, distributes, and consumes products, basic necessities, and the collective wealth. It requires the development of a project of social transformation that comprehends, critiques, and modifies the global system of capitalist domination, which has extended throughout the world its capacity to exploit, ravage, exclude, and exterminate.

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