

**REPORT OF CIVIL SOCIETY ORGANISATIONS ON  
THE SITUATION OF ECONOMIC, SOCIAL,  
CULTURAL AND ENVIRONMENTAL RIGHTS IN  
MEXICO  
(1997-2006)**

**ALTERNATIVE REPORT TO THE IV PERIODIC REPORT OF THE  
MEXICAN STATE ON THE IMPLEMENTATION OF THE ICESCR**

*Presented to the United Nations Committee on Economic, Social  
and Cultural Rights by the signatory Mexican  
civil and social organisations*

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**MEXICO, APRIL 2006**

**RIGHT TO HEALTH<sup>284</sup>**  
**(Article 12 of the ICESCR)**

### **1. Relevant data on inequality and the right to health in Mexico**

Given that the problem of inequality is one of the biggest challenges faced by Mexico in the area of development, it is very important to assess in their proper place the “average numbers” that are established at the national level and through which the improvement of the health of the population is argued in the IV Periodic Report of the Mexican State.

Although it is difficult to have precise information to be able to compare the inequalities in health that are revealed through contrasting different regions of the country, the Human Development Index (HDI) calculated by the UNDP for the Federal District and 31 states of the country allows one to have an important approximation of this. According to the Human Development Report for Mexico 2004, the country faces dynamics of inequality in education, health and access to resources that are reflected at the regional and local levels.

The UNDP generally uses information on life expectancy at birth as an indicator to calculate the health component of the HDI; however in the HDI for municipalities the infant survival rate was used as a complement to the infant mortality rate, which is a statistic available for the country’s municipalities. The Report indicates that according to the health index, 68.2% of the Mexican municipalities have medium human development and around 31.8% high human development. The differences in the health index between states are 6.5%, but among the municipalities the differences reach 95.05%, with the state of Guerrero presenting the largest differences between its localities, and the Federal District with the lowest level of internal differences. The case of Nayarit can be used to illustrate the disparities in the health index between municipalities of the same state, where one municipality (Tepic) has a health index comparable to Costa Rica and another (Del Nayar) comparable to Ghana. Veracruz, Puebla, Oaxaca, Guerrero and Chiapas are the five states that concentrate 39.7% of the national inequality in the health index.<sup>285</sup>

### **2. Fragmentation of the health system in Mexico**

The performance of the Health System in Mexico during the last few years can be characterised through two central and joined together processes: the fragmentation and deterioration of the quality of its services caused by the systematic and progressive reduction in public spending on this matter.

- a. The fragmentation of the health system and progressive minimisation of the services granted to the “open population”. An example of this type of measure is the so-called “Basic Package” (*Paquete Básico*) which reduces the right to health to 13 minimal health actions and, more recently, the “Health for Everyone Programme” (known as People’s Health Insurance), which needs to be analysed due to the budgetary investment in the programme and because it is presented as an alternative for medical attention for more than 50% of the

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<sup>284</sup> This section was elaborated by Alejandro Cerda García of the *Coordinadora Comunitaria Miravalle (COCOMI)* and the *Centro Antonio de Montesinos (CAM)*, with contributions from *ELIGE Red de Jóvenes por los derechos sexuales y reproductivos*, and *FUNDAR Centro de Análisis e Investigación*.

<sup>285</sup> United Nations Development Programme. *Human Development Report for Mexico 2004. The challenge of local development*. Mundi-Prensa, Mexico, 2005, pgs. 53-58, 75. [The calculations are based on official data from 2002].

Mexican population who does not have social security. Another example of the fragmentation and inequality of public spending designated for the health of the part of the population who has formal work, in contrast to those who do not, is the existing difference between the resources per habitant assigned for each of the current sub-systems, where 1,741 pesos are spent annually for each insured habitant, and only 1,144 pesos per year for someone who is uninsured.<sup>286</sup>

- b. The reduction in the quality of the services as a result of the budget cuts and under the logic of commercialisation, which is a situation used as a neo-liberal argument to suggest privatisation in light of the “inefficiency” of the public services. On one hand, this situation is expressed in the high number of complaints presented in the last few years to the National Human Rights Commission (CNDH) against public health institutions, which is in one of the highest in relation to complaints against other public institutions.<sup>287</sup> On the other hand, there is a progressive reduction, at least as of 1995 to date, of the number of doctors and beds per one thousand habitants.<sup>288</sup>

### 3. Population lacking guaranteed attention

There is no precise and up-to-date information regarding the population that does not have access to health services since in a systematic manner the government’s reports refer to the “potential coverage” of the services, that is, the users that under an unknown calculation could hypothetically make use of these services, cancelling out the possibility of having a precise number of the people without health services. With these provisos, it is possible to locate the official data that, for example, in 1996, 10 million people did not have access to any form of health services.<sup>289</sup>

In relation to the population with social security, it is observed that this population reached its highest point in 1990, where according to official numbers, 56% of the Mexicans benefited from this type of service. After this date, the percentage of the population with social security began to decline, dropping to 47% in 1995<sup>290</sup>, while in 2001 this indicator was at approximately 50%.<sup>291</sup>

### 4. Economic indicators and public expenditures in health

The following table, elaborated with information from the IV Periodic Report of Mexico, reflects the decrease in public expenditure for health care, a tendency that appears more conclusive if the inflationary process that the country has experienced in the last few years is considered.

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<sup>286</sup> Office of the UN High Commissioner for Human Rights (OHCHR) in Mexico, *Diagnosis on the Human Rights Situation in Mexico*. Op. Cit, 2003.

<sup>287</sup> Centro de Derechos Humanos F. F. de Vitoria. *Informe sobre la situación de los DESC*. Mexico, 2003.

<sup>288</sup> OHCHR Op. Cit.

<sup>289</sup> Federal Executive Branch, 1996. Cited by Laurell, Asa Cristina. *Mexicanos en Defensa de la Salud y la Seguridad Social*. Editorial Planeta Mexicana, Mexico, 2001.

<sup>290</sup> Federal Executive Branch, 1994 and 1999. Cited by Laurell, Asa Cristina. *Los mexicanos en defensa de la salud...* Op. Cit. 2001.

<sup>291</sup> Official Journal of the Federation. *Reglas de operación del Seguro Popular*, Mexico, 15 March 2002.

**Table 1: Investment in health care in Mexico, 1997 – 2002**

Year	% of GDP, including public and private expenditure, devoted to health care	% of public expenditure devoted to health care*	Public expenditure in health care as a % of GDP**	% of private expenditure on health care*	Private expenditure in health care as % of GDP**
1997	5.5	45.3	2.49	54.7	3.00
2002	5.8	42.1	2.44	57.9	3.35

\* Numbers taken directly from the IV Report of the Mexican State to the Committee on ESCR

\*\* Calculation elaborated based on official numbers.

Source: Own elaboration based on the data included in the IV Periodic Report submitted by the government of the United Mexican States in fulfilment of its obligations in the ICESCR.

Even before of the application of structural adjustment policies in Mexico, little importance was given to expenditures in health care during the last few decades, a situation that can be considered even more serious if Mexico is compared with other Latin American countries. In Mexico, “public expenditure in health care reached only 2% of the GDP, an expenditure less than that assigned by other countries with the same level of development, which is between 3 and 5%, and of developed countries, which is around 9%”.<sup>292</sup> The Diagnosis of the OHCHR in Mexico comes to similar conclusions: “In fact, the ratio of public expenditure in health care as a percentage of total public expenditure represents almost a third of what is exercised in Colombia and less than half of that exercised in Chile. Since the decline of this ratio beginning in 1999, this situation has worsened, placing itself in levels similar to those of 1994”.<sup>293</sup>

The budget decrease is confirmed in the public health institutions for the insured population as well as in the services provided to the so-called open population (those who do not have benefits from the Mexican Social Security Institute –IMSS- or the Social Security and Services Institute for State Workers -ISSSTE). Among the most relevant data that supports this tendency we find, for example, the progressive reduction of IMSS’ budget during the last two decades<sup>294</sup> and the reduction of the budget for the Programme IMSS-Opportunities of between 30 and 50% during the period 2000-2003.<sup>295</sup>

The expenditure on health care per habitant for 2002 registered a decrease of 16 % in real terms with respect to 2001 for the insured population, and for the uninsured population it remained practically stagnant between 1999 and 2002.<sup>296</sup> This process of reducing public expenditure on health care has a counterpart in the implementation of mechanisms for the *selective privatisation* of health services, given that the alternative of leaving health services in the hands of private actors is mainly focused on those services that are more profitable because of their intrinsic cost or the purchasing power of the target population. In contrast, the services that are not very profitable and that are intended for the population with scarce resources, which in most cases forms part of the informal sector, continue to be considered a responsibility of the State, but with a

<sup>292</sup>Laurell, Asa Cristina. *Mexicanos en defensa de la Salud...* Op. Cit. 2001, p. 72.

<sup>293</sup> UN Office of the High Commissioner for Human Rights in Mexico (OHCHR), *Diagnosis on the Human Rights Situation in Mexico*. Op. Cit, 2003, p. 94

<sup>294</sup> Laurell, Asa Cristina. *La contrarreforma en salud...* Op. Cit. 2001

<sup>295</sup> OHCHR Op. Cit.

<sup>296</sup> OHCHR Op. Cit.

tendency to progressively and markedly restrict the resources assigned to them and the services they include.

#### 4.1 HIV/AIDS and the federal budget<sup>297</sup>

The Mexican government's Progress Report 2005 on the Millennium Development Goals (MDGs) affirms that combating HIV/AIDS is a national priority and that to achieve this, part of the policies will focus on prevention. It states that from 2000-2004, the resources designated to the action programme for the prevention and control of HIV/AIDS increased by more than 14 times, recognising that basically the increase was due to the purchase of antiretroviral medicine (ARVs). It is precisely the disparity of the resources between treatment (basically ARVs) and prevention, which causes the current strategy to be inconsistent with the discourse and priority that is sought to be granted to HIV/AIDS. In state government expenditures as well as the federal government's expenditures in the area of prevention, examples exist that show that this increase has not been proportional. The resources that are being invested in the prevention of HIV continue to be insufficient.

According to numbers from the National Centre for the Prevention and Control of HIV/AIDS (CENSIDA), from 1999 to 2002, the state governments increased the expenditure for ARVs as well as for condoms. However, the proportion of the increase in both areas is very unequal: for ARVs, the expenditure in 2002 represented 43 times more than that designated in 1999; while for condoms, in 2002 it was only 4.6 times more than what had been spent in 1999.

The former Executive Coordinator of the Regional Initiative on AIDS for Latin America and the Caribbean,<sup>298</sup> stated that the scarce resources for prevention need to be focused on the most vulnerable groups to ensure that the epidemic does not get out of control- passing from an epidemic concentrated in men who have sex with men to a generalised epidemic. The studies of national accounts on HIV/AIDS illustrate that in Mexico only 13% of what is spent on prevention is focused on at risk populations, calculating that of the expenditure for condoms, only 10% is directed at men who have sex with men.<sup>299</sup>

Regarding CENSIDA's expenditure since 2002, for the first two years (2002 and 2003), it should be mentioned that prevention is by far the most punished component of federal spending, accounting for only 7 and 2.5% of the total resources exercised by CENSIDA in 2002 and 2003, respectively.

If the prevention efforts are not increased, particularly in regards to the sexual transmission of the epidemic, focused especially on the most at risk groups, Mexico will irremediably move close to a point where there are not enough resources to provide treatment and medicine to the persons who live with AIDS. One cannot attempt to continue to indefinitely increase the resources necessary to cover the demand for ARVs without carrying out serious efforts to contain the epidemic.

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<sup>297</sup> Information provided by *FUNDAR Centro de Análisis e Investigación* for the chapter on Mexico of the Social Watch Report 2005 "Roars and Whispers: Gender and poverty: promises vs. action" available at: [www.socialwatch.org](http://www.socialwatch.org)

<sup>298</sup> A. Brito, "La decisión del gasto en prevención, discriminatoria" interview with José Antonio Izáola, *Suplemento Letra S in La Jornada*, 6 November 2003, p.9.

<sup>299</sup> José A. Izáola, Ed., *Sistemas de información de respuestas nacionales contra el SIDA: Indicadores financieros. Flujos de financiamiento y gasto en VIH/SIDA. Cuentas Nacionales en VIH/SIDA. México 1999-2000*, Funsalud, Mexico, 2002, pp. 9 y 26.

## 5. Sexual and reproductive health

The right to the protection of motherhood is directly related to the situation of reproductive rights in Mexico. The protection of mothers continues to be a right denied to thousands of Mexican women. The public policies directed at the respect, protection and promotion of reproductive rights and towards the respect, promotion and protection of maternity in Mexico have been limited and report little substantial advancement.

Due to its importance and the Committee's special interest in the problem of abortion as the fourth cause of female mortality in Mexico, a section of this Alternative Report, under Article 10 of the ICESCR on the right to protection and assistance to the family, paragraph 2: protection to mothers, covers this issue.

### 5.1 The sexual and reproductive rights of the young people in Mexico<sup>300</sup>

According to numbers from the National Population Council (CONAPO), the events associated with pregnancy, delivery and puerperium are an important cause of death among young women, representing 5.3% of the deaths of women between 15 and 19 years old and 9.4% of the 20 to 24 year olds, which means the fifth and second causes of death in these age groups.<sup>301</sup> Data from 1995 highlights that prenatal care reached 90%, however, attention during delivery was lower, reaching only 81.3%, with very marked differences between rural and urban areas (in prenatal care the difference is almost 10% while in attention during delivery, it is close to 28%) and 70% in the puerperium (a percentage that is reduced to 50% in small communities.)

In light of this situation, the government has promoted certain actions to reverse this inequality, such as the Equal Start in Life Programme (PAPV)<sup>302</sup> that seeks to guarantee a safe delivery and a puerperium free of complications for all Mexican women. However, at the end of 2003, this programme was only operating in 17 states and its results estimated that the prenatal control consultations grew on an average of 8% in this year. The panorama on the sexual and reproductive health of the young Mexican population illustrates that, while progress has been made, it is clear that the full enjoyment of this right is still not guaranteed by the State and that in fact, the omissions as well as deficiencies in practice indicate a violation of the rights of young people.

### 5.2 Limitations of the Equal Start in Life Programme

The government of president Fox designed the Equal Start in Life Programme (PAPV) to reduce maternal mortality rates, and it is one of the significant strategies of the Federal Government's National Health Programme 2000-2006.

There are serious limitations in this programme. On the one hand, the formation of said programme lacks a human rights focus. It is designed without taking into account the diversity of the socio-cultural aspects of the women that it is directed at; with a total absence of the issue of abortion, a problem deeply related to maternal deaths. Another serious and related deficiency of the programme is that it leaves out the issue of whether each pregnancy and each birth are desired, that is, it does not promote the

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<sup>300</sup> Information provided by *Elige, red de jóvenes por los derechos sexuales y reproductivos*.

<sup>301</sup> *Situación actual de las y los jóvenes en México. Diagnóstico sociodemográfico*, Chapter VII "La salud de las y los jóvenes", Chapter VIII "Juventud y reproducción", Mexico, CONAPO, 2000, pp. 44-63

<sup>302</sup> A critical analysis on the functioning of PAPV can be found in the section of this Alternative Report on Art. 10 of the ICESCR, in regards to maternity.

right to a freely decided maternity with quality care. These are fundamental aspects for the exercise of reproductive rights.<sup>303</sup>

On the other hand, the designated resources are insufficient and a pattern of inequality in the designation of resources to the states of the Republic prevails. For example, in 2003 the state of Chiapas, which has a maternal mortality rate of 9.32, was assigned 926 thousand pesos, while Nuevo Leon, with a rate of 2.8, received close to 24 million, representing 26 more times than that designated to Chiapas.<sup>304</sup>

More recently, the health authorities emitted an Agreement where they establish common and permanent strategies throughout the country for epidemiological vigilance of maternal deaths in the framework of the Equal Start in Life Programme, as well as the elaboration and application of preventative and corrective measures.<sup>305</sup>

## **6. The right to health in the IV Periodic Report**

In a revision of the IV Report of Mexico to the Committee on Economic, Social and Cultural Rights on the measures adopted in the period 1997-2004, three particularly relevant aspects to evaluate the evolution of the right to health during said period can be identified: 1) the percentage of the Gross Domestic Product (GDP) devoted to healthcare; 2) the differences between the incidence rates of illnesses associated with poverty in distinct regions of the country; 3) the creation of the Social Health Protection System, implemented through the so-called "People's Health Insurance".

### **6.1 Percentage of the GDP devoted to healthcare**

The answer provided by the Mexican State to the request to indicate "the percentage of the country's GDP, as well as of its national and/or regional budgets, devoted to healthcare... Compare this situation with that which existed five and ten years ago"<sup>306</sup>, causes confusion by considering the total percentage that includes private and public expenditures on healthcare. Through said calculation, it is reported that the percentage of the GDP increased from 5.5% in 1997 to 5.8% in 2002. However, a more detailed examination of the data<sup>307</sup> upon comparing 1997-2002 shows that in reality there was a reduction in *public expenditure* in healthcare. This is because, as the IV Periodic Report indicates, "In 2002, Mexico devoted 5.8 per cent of its gross domestic product (GDP) to health care. This figure includes both public expenditure (42.1%) and private expenditure (57.9%). In 1997 health expenditure amounted to 5.5 per cent of GDP, with private expenditure accounting for 54.7 per cent of the total and public expenditure 45.3 per cent."

### **6.2 Differences between the incidence rates of illnesses associated with poverty in the different regions of the country**

In relation to the request to report "... if they are available, the indicators defined by the WHO regarding the following issues: a) Infant mortality rates (apart from the national rate, please indicate the rate by sex, urban and rural areas and also, if possible, by

<sup>303</sup> FUNDAR. *La Mortalidad Materna: Un problema sin resolver*. Mexico, 2002. And, Foro Nacional de Mujeres y Políticas de Población. *Morbimortalidad Materna: Monitoreo y Elaboración de Propuestas para Políticas Públicas en México*. October, 2002

<sup>304</sup> FUNDAR, Centro de Análisis e Investigación, A. C. "Presupuesto Público y Mortalidad Materna: Seguimiento al programa *Arranque parejo en la Vida*". Mexico, 2003.

<sup>305</sup> This Agreement establishes the obligatory application by the public and private institutions of the National Health System of the substantive and strategic components of the Equal Start in Life Programme and the active epidemiological vigilance of maternal deaths. Published on 1 November 2004, in the Official Journal of the Federation, pgs. 70-74.

<sup>306</sup> *IV Periodic Report of Mexico to the Committee on Economic, Social and Cultural Rights*, (E/C.12/4/Add.16).

<sup>307</sup> See table 1 of this section.

socio-economic and ethnic groups and geographical areas...)", the Report of the Mexican States commits the error of providing this data in absolute numbers<sup>308</sup> and in some cases, it indicates the percentages.<sup>309</sup> As the data is not provided in terms of "rates", it is impossible to elaborate comparisons both in terms of time (1997-2004) as well as regarding different states or municipalities in the country.

In spite of the lack of information on this section in the IV Report, there is official data that demonstrates, for example, large differences in the number of doctors per 100 thousand habitants in different states of the country. According to the numbers presented in Table 2 below, poor states such as Chiapas, Guerrero and Oaxaca have remained, even in 2005, in a situation that places them well below the national mean. In the state of Chiapas, a decrease in the number of doctors per 100 thousand habitants is registered, while in the state of Oaxaca, in spite of an increase in said indicator, the situation continues to be below the national average.

**Table 2: Number of doctors per 100 thousand habitants in select states, 2000-2005**

	2000	2005*	% increase
National	114.5	133.2	16.3
Federal District	268	329	22.7
Nuevo León	125	134	7.2
Chiapas	92	90	- 3.2
Guerrero	100	115	15
Oaxaca	86	113	31.3

Source: Presidency of the Republic, Fifth Report of the Government 2005, p. 106-110.

\* Estimated numbers.

### 6.3 The Social Health Protection System and "People's Health Insurance"

The Report of the Mexican State indicates that in January 2004 "a universal social security scheme, known as the Social Health Protection System, came into force. The aim of this system is to offer equal opportunities to all Mexicans with respect to participation in public health insurance."<sup>310</sup> The People's Health Insurance scheme constitutes the operational arm of the system, which will regulate the sources of financing between IMSS<sup>311</sup>, el ISSSTE<sup>312</sup> and National Insurance through shifting from "an emphasis on supply to the subsidizing of demand" with the aim to "reduce inequalities between states and social groups."<sup>313</sup>

In spite of the fact that the Mexican State conceives People's Health Insurance as an instrument that will provide health services to 50% of the Mexicans who do not have

<sup>308</sup> See the Tables on the deaths of children less than one year of age and deaths of children between ages one and four in the section on the right to health in the IV Periodic Report of Mexico to the CESCR.

<sup>309</sup> See the table on Access to attention by trained personnel and the beneficiary population of health services, Causes of general deaths, etc. in the section on the right to health in the IV Periodic Report of Mexico to the CESCR.

<sup>310</sup> *IV Periodic Report of Mexico to the Committee on Economic, Social and Cultural Rights*, E/C.12/4/Add.16, 2005, paragraph 519, page 121.

<sup>311</sup> The Mexican Social Security Institute is a governmental institute that provides healthcare services and social security to workers in the private companies and institutions that are registered and pay into this institute.

<sup>312</sup> The Social Security and Services Institute for State Workers is a governmental institute that provides healthcare services and social security to workers in the public sector.

<sup>313</sup> *IV Periodic Report of Mexico to the Committee on Economic, Social and Cultural Rights*, E/C.12/4/Add.16, 2005, paragraph 528.

social security, different social sectors<sup>314</sup> and academics<sup>315</sup> in Mexico have expressed their rejection of the implementation of said programme because they consider it to be an instrument that institutionalises a regression in the area of the right to health in Mexico, through violating the principles of being universal and free as recognised in the Constitution.

A quick comparison of the services received by a worker who is affiliated with IMSS with those of a person or family who is registered with People's Health Insurance<sup>316</sup> allows us to observe that in the case of the latter the components of social security are restricted, as healthcare and medicines are constrained; apart from limiting the number and type of services, as well as access to medicines:

- a. In regards to the programme's design, it can be observed that it is based on a principle through which social security (medical attention, housing, maternity insurance, disability, retirement, old age, pension) is limited to financial security-making a pre-payment that avoids spending at the moment in which the illness occurs- which is focused on providing health services with restrictions. In this way, a great expectation is created for the population who is not enrolled in a social security system, but this is not supported by a true growth in the infrastructure, personnel, and services in accordance with the demand that is generated.
- b. The provision of services and access to medicines is limited to those ailments included in a very limited list (this list initially included treatment for 78 illnesses,<sup>317</sup> and subsequently this was increased to 154 ailments<sup>318</sup>), as compared to IMSS, which offers integral attention.<sup>319</sup> In spite of the fact that People's Health Insurance is proposed as an alternative for close to 50% of the Mexicans who do not have access to IMSS or ISSSTE, it only includes 11 of the multiple ailments that require hospitalisation, giving rise to a fragmentation of the National Health System and the creation of discriminatory mechanisms by establishing different types of services for citizens in different socio-economic and labour situations.

The criteria to include/exclude a determined type of service or medicines is purely financial, so that ailments especially linked to the possibility of violations of the right to health, such as attention to persons with HIV/AIDS, are excluded.<sup>320</sup> Likewise, through People's Health Insurance there is no possibility of having legal abortion services, a situation associated with high female mortality rates, which was the grounds for a specific recommendation of the Committee on ESCR in 1999.<sup>321</sup> This omission is particularly serious since it does not recognise the causes for abortion that have been legally approved in

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<sup>314</sup> Centro de Derechos Humanos Fray Francisco de Vitoria. *Informe sobre la situación de los DESC*. Mexico, 2003.

<sup>315</sup> Laurell, Asa Cristina. *Mexicanos en Defensa de la Salud...* Op Cit.

<sup>316</sup> Official Journal of the Federation. *Reglas de operación del Seguro Popular*, Mexico, 15 March 2002.

<sup>317</sup> Official Journal of the Federation. *Reglas de operación del Seguro Popular*, Mexico, 15 March 2002.

<sup>318</sup> This information is available at: Ministry of Health. [www.salud.gob.mx](http://www.salud.gob.mx). Internet consultation, 21 March 2006.

<sup>319</sup> People's Health Insurance does not include particularly important ailments such as complications in delivery, complications for newborns, and hospital attention for persons with HIV/AIDS, among others.

<sup>320</sup> This serious omission can be confirmed at: Ministry of Health. [www.salud.gob.mx](http://www.salud.gob.mx) / Seguro popular / Beneficios. Internet consultation, 21 March 2006.

<sup>321</sup> People's Health Insurance only includes the medical services for performing "uncomplicated" abortions or those that, according to medical terminology, are classified as being "in development." This means that medical services are not provided for "complicated" abortions, which are clearly those that are mostly related to female mortality and which also require more hospitalisation expenses. Likewise, medical services for abortion are not included in those cases where the pregnancy is not yet evident, that is, those that could be explicitly requested by women who do not yet present symptoms but who have decided to have an abortion based on the grounds currently permitted by law. The information on attention to abortion in People's Health Insurance can be seen at: Ministry of Health. *Seguro popular / Beneficios*. Internet consultation, 21 March 2006.

several states in Mexico, such as cases where the pregnancy is the result of rape.

- c. One of the mechanisms to finance the programme is the “pre-payment” modality that suspends the service when the contracted period ends.<sup>322</sup> Likewise, the People’s Health Insurance Programme is in a very vulnerable situation and it is subject to the possibility of being modified and having its resources reduced or eliminated, since the resources come from the section of the public budget destined for “subsidies”. The programme does not have enough institutionalism to allow it to have its own annual budget. This is more difficult to implement in the services provided by IMSS or ISSSTE.

The operation of this programme has made evident the multiple limitations faced in the financial sphere. According to the criteria of the Law, 5 billion 541 million pesos will be assigned in the 2004-2010 period, which is enough money to build 11 general hospitals.<sup>323</sup> Therefore, if one considers the real health needs of the population that is not enrolled in a social security system and that would eventually agree to this programme, it is evident that an unviable financial mechanism is being proposed.

Likewise, the Programme does not plan for mechanisms that contribute to reduce the limitations in the infrastructure and services. By implementing proportional mechanisms to assign the federal budget to the resources designated for each state, inequality among the states is favoured as the poorest states will have less opportunity to contribute state resources and therefore, they will receive less federal funds.

Apart from substituting the notion of a social right for one of a service that is exchanged for monetary resources, the “pre-payment” mechanism, which is one of the central axes of People’s Health Insurance, represents a step backward in the area of the right to health since if the designated quotas are not covered, the service is not given.<sup>324</sup> Under this mechanism, the citizens and their families who have contracted a chronic disease or an illness that lasts beyond the time covered by their quota, no longer receive medical attention. This situation signifies a regression in the health services that the State previously was providing, with an additional difficulty if it involves persons with a particularly urgent need for attention. The pilot implementation of this programme has meant that some states have the possibility to increase their expenditure in health. At the same time, it has generated the opposition of the health service providers who directly face the demand the programme generates.

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<sup>322</sup> As can be seen in the Rules of Operation of People’s Health Insurance, Op. Cit. and in the web page of the Ministry of Health ([www.salud.gob.mx](http://www.salud.gob.mx)), access to benefits is contracted for one year through a “pre-payment” whose amount is set according to the “decile of income distribution” that the person is in: “As in any insurance scheme, the Ministry of Health offered a series of explicit benefits which the insured had access to in the case of suffering from any event that harmed his/her health, always and when said event was included in the coverage granted and his/her rights to those services were in effect.” Internet consultation, 21 March 2006.

<sup>323</sup> Based on information from *FUNDAR Centro de Análisis e Investigación*. [www.fundar.org.mx](http://www.fundar.org.mx)

<sup>324</sup> While the Rules of Operation of People’s Health Insurance exclude from payment the families that are in the two lowest “deciles of income”, the families who are in the four following deciles, which are considered the beneficiaries of People’s Health Insurance, are required to pay a “pre-payment” fee and eventually, if they do not pay the respective fees in advance, that is, at the beginning of the year for which they are contracting access to the Programme, they may no longer receive the benefits of the Programme. In this same sense, see footnote number 39 of this chapter.

## **7. Health and the environment: the case of the contamination of the Santiago River in the state of Jalisco<sup>325</sup>**

The serious environmental deterioration in the municipalities of El Salto and Juanacatlán in the state of Jalisco, in particular of the Santiago River (which crosses both municipalities), has been caused by the large concentrations of pollutants that are a product of the industry that surrounds these municipalities, and of the residual municipal waters that come from the metropolitan area of the city of Guadalajara. The lack of an effective enforcement of the Mexican environmental laws by environmental authorities, as well as the lack of awareness by businesspeople and citizens in general, affects the environment and has a serious impact on the health of the population of the riverside area. The municipalities of Juanacatlán and El Salto together have 150,000 inhabitants; and El Salto has one of the most important industrial corridors of the state of Jalisco.

The Environmental Study of Sulfhydic Acid as an air pollutant in the communities of Juanacatlán and El Salto, Jalisco, carried out in 2004-2005, found evidence that in a radius of 1.5 kilometres around the El Salto de Juanacatlán waterfall, particularly public areas such as: parks, recreational areas and schools (kindergartens, and primary and secondary schools), the average concentration of sulfyhdric acid in the air was 2ppm (particles per millimetre), approximately 10% of the registers ranged between 4 and 6 ppm; and in the test taken on the bridge of the waterfall, 7 ppm.

Said study concludes that:

1. More than a third of the population of these municipalities suffers from respiratory problems.
2. The generation and emission of sulfhydic acid in the atmosphere can be considered to be from a fixed source, which makes the federal authority responsible for its control.
3. There is a health emergency in the municipalities of Juanacatlán and El Salto seen in the cases of cancer and serious respiratory illnesses (among the most important) that are caused by direct contact with the subterranean and superficial hydric sources that pass through the area. Because of this, there is a systematic violation of the human right to health.
4. The concentration levels of sulfhydic acid in the air of the area that intersects the above mentioned municipalities is beyond the parameters for human inhalation; likewise it is necessary to undertake an in-depth study by the sanitarian authorities regarding the health consequences of said acid and the ways in which the damages it produces can be reversed.

Recommendation: The State, in its three levels of government, should take urgent and immediate precautionary measures directed at the sanitary and environmental restoration of the municipalities of El Salto and Juanacatlán, given the evidence of serious and irreversible damage to health and the environment.

## **8. Questions for the Mexican government**

- A. What was the reason for reducing the public resources designated for health in the period 1997-2002, as is illustrated in Table 1?

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<sup>325</sup> The content of this section has been taken from the: Instituto Mexicano para el Desarrollo Comunitario, A.C. *Mártires del Río Santiago. Informe sobre violaciones al derecho a la salud y al medio ambiente en las poblaciones de Juanacatlán y El Salto, Jalisco*. Photocopy. Mexico, 2006.

- B. What is the reason for not providing data on the “rates” of infant mortality and maternal mortality separated by states and municipalities, which would illustrate the persistent and accentuated inequalities in the country?
- C. Why does the government consider that an initiative of the Federal Government of the size and importance of “People’s Health Insurance” should not be directed towards guaranteeing the “right to protect health” but rather to “provide financial protection to the population who does not have social health security by incorporating it into an insurance scheme”?
- D. According to statistics, the poorest states of the country are also those that have less healthcare infrastructure and a larger percentage of the population who earns less than two minimum wages. Does the mechanism to designate resources according to the number of persons who register with People’s Health Insurance and the established capacity to provide the services contribute to deepening even more the inequality in the access to health services?
- E. In light of the existence of the Social Security System (IMSS and ISSSTE) and of the services provided by the Ministry of Health, does the creation of a new mechanism that provides services and medicine in a differentiated way such as those that are now offered to the users of People’s Health Insurance, contribute to offering “different types and magnitudes of services” for “different populations according to their labour condition and income” and promote in this way discriminatory attention?
- F. Recognising the financial limitations coming from the budgetary allocations for healthcare expenditures in Mexico, why doesn’t the People’s Health Insurance offer to its affiliates attention to ailments of an increasing occurrence or of transcendental importance such as the treatment of HIV/AIDS, the practice of abortion in the cases permitted by the current legislation (particularly resulting from rape) and in the cases of “complicated abortions” (associated in an important way with maternal mortality) , the different forms of cancer or compound fractures, among others, while this is foreseen for the affiliates of IMSS and ISSSTE?
- G. What are the measures that have been adopted by the Mexican State regarding the case of the contamination of the Santiago River in the state of Jalisco and its effects on the health of the area’s residents?