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# HEALTH CARE: AQUESTION OF HUMAN RIGHTS, NOT CHARITY

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## 1. AN INITIAL PERSPECTIVE ON ECONOMIC AND SOCIAL RIGHTS

At the beginning of the 21st century the economic and social well-being of large parts of humankind face the challenge of reverting the growing social and economic alienation of the poor. It has been estimated that 1.3 billion people—70 percent of whom are women—lack access to adequate food, water, sanitation, essential health care, or primary education.[1] The richest fifth of the world's population accumulates 85 percent of global income while the poorest fifth receives 1.4 percent of it.[2]

Yet the dominant perspective accepts that the basic needs of millions of people will go unmet as an unavoidable side effect of the global market. Markets are structured to respond to the interests of those with adequate income, wealth and access to information. The human needs of those without "market power" are rendered invisible, and only partially addressed by governmental resource allocation. Economic and social issues have been regarded "as optional policy objectives rather than matters of fundamental human rights".[3]

As a consequence of the ideological struggle that characterized the Cold War, economic, social, and cultural rights (ESCR) were separated from civil and political rights (CPR), by establishing a conceptual difference between integral parts of a comprehensive core of fundamental rights. This distinction was framed in terms of "negative" civil and political rights and "positive" social and economic rights. While it was considered that "negative rights require only the forbearance of others to be realized, […] positive rights require that others provide active support".[4]

This artificial distinction, which has only been discarded recently, left out the fact that all human rights entail both positive and negative obligations, in the form of respect, protection and fulfillment. Respect and protection require States to refrain from interfering with the enjoyment of a certain right and to prevent violations by third parties; fulfillment demands appropriate **legislative, administrative, judicial and budgetary measures** towards full realization of the right.[5] Neither CPR nor ESCR can be fully achieved without all obligations being consistently pursued.

Human rights "entitle human beings and groups to a certain existential status and put an obligation on States to do the best they can to satisfy this related existential status"[6]. This implies the obligation for States to respect a basic level of subsistence necessary to live in dignity, protect that basic level against being undermined by third parties, and take appropriate measures towards its achievement by deprived people.[7]

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[1] UNHCHR, "Human Rights", Special Issue on Women's Rights, Spring 2000, Office of the High Commissioner for Human Rights, pp. 3 and 12.
[2] J. Häusermann, "An Emerging Consensus on the Right to Development: Some Current Initiatives Relevant to the Implementation of the Right to Development", background paper for the Seminar on Right to Development: Challenges and Opportunities II, Geneva, 30 August-1 September 2000, p. 4.
[3] UNIFEM, *Progress of the World's Women 2000*, Biennial Report, UNIFEM, New York, 2000, p. 42.
[4] J. Donnelly, *International Human Rights*, Westview Press, Boulder (CO), 1993, p. 26.
[5] M. Scheinin, "Conceptual Framework for the Discussion", Background Paper for the Women's Enjoyment of Their Economic and Social Rights, Expert Group Meeting, Abo/Turku, Finland, 1-4 December 1997, p. 9 (emphasis added).
[6] FIAN International, *Economic Human Rights: Their Time Has Come*", Heidelberg, 1995, p. 21.
[7] *Loc. cit.*

With regards to economic, social and cultural rights, governments are obliged to move "as expeditiously and effectively as possible" towards their realization, making "full use of their **maximum available resources**".[8] While it is recognized that progressive realization depends of the availability of resources, the concept itself "does not permit the perpetuation of economic injustice and disparity"; it also prohibits "a government from cutting back on basic services…"[9] Furthermore, the Committee on Economic, Social and Cultural Rights underscored that "a State party in which any significant number of individuals is deprived of essential foodstuffs, of essential primary health care, of basic shelter and housing, or of the most basic form of education, is, *prima facie*, failing to discharge its obligations under the Covenant [on Economic, Social and Cultural Rights][10]".

As a contrast to the progressive realization clause, the prohibition of discrimination in access to economic, social and cultural rights is an immediate duty. Non-discrimination not only implies the absence of a discriminatory legal framework, but also includes that policies are not to be discriminatory in their effects[11]—by allowing access to certain groups but excluding others in practice. As a result, governments have an obligation to implement concrete and deliberate programmatic action in order to narrow existing inequities, and thus ensure the enjoyment of ESCR by all.

## 2. THE RIGHT TO THE HIGHEST ATTAINABLE STANDARD OF HEALTH: A FRAMEWORK FOR ANALYSIS

During the first half of the last century it was common for health to be defined negatively, as the absence of illness. This concept changed radically with the principles that rule the World Health Organization (WHO), which defined health positively, as "a State of complete physical, mental and social well being, and not just the absence of diseases and illness"[12]. Since then, health has been understood in terms of its relationship to the environment, nutrition, working and overall human conditions—including poverty and income distribution.

As a result of this comprehensive conception, health started to be considered as a fundamental part of human rights. The WHO's constitution States that "the enjoyment of the highest attainable standard of health is a fundamental right of every human being, regardless of race, religion, political ideology, social or economic condition"[13]. The importance of the enunciation of this principle stems from the fact that it was the first time States recognized the right to "the highest attainable standard of health, under the parameters of universality, without discrimination of any type, securing equitable access and enjoyment"[14].

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[8] UN Committee on Economic, Social and Cultural Rights, General Comment 3: The Nature of States Parties' Obligations", 1993, par. 9 (emphasis added).

[9] Center for Economic and Social Rights, *Economic, Social and Cultural Rights: Guide to the Legal Framework*, New York, January 2000, p. 8.

[10] UN Committee on Economic, Social and Cultural Rights, *op. cit*, par. 10.

[11] Center for Economic and Social Rights, *op. cit.*, pp. 9s.

[12] Organización Panamericana de la Salud, "Constitución de la Organización Mundial de la Salud", en *Documentos Básicos*, Documento Oficial núm. 240, Washington, 1991, p. 23.

[13] *Loc. cit.*

[14] Provea, *La salud como derecho: marco nacional e internacional de protección del derecho humano a la salud*, Serie Aportes núm. 3, Caracas, 1996, p. 10.

Following this line, article 12 of the International Covenant of Economic, Social and Cultural Rights[15] defines the duties assumed by the States Parties in the following way:

1. The State Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary to:
   a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
   b) The improvement of all aspects of environmental and industrial hygiene;
   c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
   d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

According to General Comment 14 of the UN Committee on Economic, Social and Cultural Rights the right to the highest attainable standard of health is characterized by the following specific guiding principles:

**Universality:** universality in relation to the right to health supposes that each and every one must have access to curative, preventive and other measures related to the preservation of health, enjoying the same opportunities and benefits. In this sense, "universality also supposes that the barriers that prevent the exercise of the right in acceptable conditions must be eliminated"[16].

**Progressive realization and irreversibility:** The progressive character of the right to health implies that States have the continuous obligation to move towards its fullest realization, in the most effective and expeditious way. The right to health evolves progressively, creating referents regarding its enjoyment; achieved levels admit no drawbacks. Therefore, policies applied by governments should not lead to the diminishment of previously achieved standards of health services, regardless of economic or political conditions[17].

**Availability:** Implies a functional public health system, services and facilities that guarantee proper attention, as well as a wide range of programs that ensure access to clean water and adequate sanitary conditions; hospitals, clinics and other instances related to healthcare. This also includes attention by well-trained health professionals, and the existence and supply of essential medicines[18].

**Accessibility:** This principle comprehends the access to health services throughout different life stages, regardless of geographical location. This means that health services ought to be accessible to everyone without discrimination, particularly to the most

[15] Adopted by the UN General Assembly on September 16, 1966. Came into effect on January 3, 1976.
[16] Provea, *op. cit.*, p. 30.
[17] UN Committe on ESC Rights, "General Comment 14…", o*p. cit.*, par. 31 y 32.
[18] *Ibid.,* par. 12

vulnerable or marginalized sectors of society, implying physical, economic and information accessibility[19].

**Non-discrimination and equity:** This principle refers to non-discriminatory practices and services, in the sense that everyone ought to have the right to access the healthcare system, and to enjoy its benefits, without any distinction. However, this doesn't mean to ensure the same for everyone in a uniform way, but to guarantee similar opportunities to those sectors that face greater obstacles in the access to health, particularly to the most vulnerable sectors. Equity implies the distribution of budgetary, technical and human resources on the basis of individual and collective needs.

**Quality:** The facilities, goods and health services must be scientifically and medically appropriate and of good quality, This requires skilled medical personnel, scientifically approved and unexpired medicines, as well as the necessary medical equipment, safe water and adequate sanitary conditions.[20]

**Cost-freeness:** The Sate has the obligation to guarantee health to the whole population, especially the most vulnerable sectors and those who lack access to social security systems. Cost-freeness directly relates to accessibility, since it has been proven that user fees diminish the demand of sanitary services[21].

## 3. THE RIGHT TO HEALTH IN THE MEXICAN CONSTITUTION AND IN THE GENERAL HEALTH BILL

Article number 4 of the Mexican constitution states that "every person has the right to health". According to the general health bill, which is the legal framework that details the actions the Mexican government ought to adopt relating health, the right to healthcare is to be understood as the enjoyment of health services and assistance that satisfy the needs of the population (art. 2).

General health is the responsibility of the Federal government and of the States, and implies among other things, medical attention**, preferably in benefit of the most vulnerable groups** (art.3). The normative faculties of health are a task that corresponds to the federal government, including medical attention to the population, while it is a task of the States to organize, operate, supervise and evaluate medical attention, among other matters (art. 13).

In the general health bill, medical attention is considered as a basic health service, including preventive, curative and prophylactic measures, as well as emergency attention (art. 27). For this purpose a basic input pool is established for the first level of medical attention, and a catalogue of inputs for the second and third levels (art. 28), which existence and availability must be guaranteed by the Ministry of Health (art. 29).

[19] UN Committee on ESC Rights, "General Comment 14…", *op. cit.,* par. 12.
[20] UN Committee on ESC Rights, "General Comment 14…", *op. cit.,* par. 12.
[21] PNUD, *Informe de Desarrollo Humano 1991*, Colombia, Tercer Mundo Editores, 1991, p. 280.

About the provision of health services, this bill establishes that they must be granted to those who need it, ensuring "the qualitative and quantitative extension of services, in preference to the most vulnerable groups" (art. 25). In addition, these services will be ruled by criteria of **universality and cost-freeness**—the later determined by the socio-economic conditions of the beneficiaries (art. 35).

However, the federal government and the States can establish user fees (recovery quotas), taking in account the cost of those services and the socio-economic conditions of the beneficiaries. These user fees should be based on the principle of social solidarity, **exempting those who cannot afford to pay them** (art. 36).

**The decentralization of resources for public health care:**

The instrument that regulates the transfer of funds from the Federal government to the States for the operation of their respective healthcare systems is the Fiscal Coordination Bill (LCF). The LCF comprehends the creation of federal contributions, called *aportaciones,* which are resources that the federal government transfers to the States in order to implement and fulfill the objectives established for each fund in the same bill (art. 25).

In the case of State healthcare systems, the LCF determines a specific fund for this purpose (*Fondo de Aportaciones para los Servicios de Salud*, FASSA), whose budget is determined on a yearly basis in the Federal Budget (art. 30).

## 4. THE NATIONAL HEALTH PROGRAM 2001-2006

At the beginning of each administration, several programs aimed at setting guidelines for governmental activities to be carried out are elaborated. These programs are part of the Democratic Planning System (*Sistema de Planeación Democrática*) and give sustenance to the National Development Plan (*Plan Nacional de Desarrollo*).

The main axis of the National Health Program (*Programa Nacional de Salud*, PNS) is the "democratization of health", which "implies setting the conditions to ensure that the whole population will have access to the corresponding services, independently from their income or the obstacles for reaching the place where they live. Health protection cannot be considered as a merchandise, object of charity, or a privilege. It is a social right…" [22]

Starting from this explicit recognition of health as a right, not as an asset or a merchandise subject to negotiation, what follows is a chart that integrates the guiding principles of the right to health, it's equivalents in the national legislation and the specific proposals that spawn from the PNS.

[22] Secretaría de Salud, *Programa Nacional de Salud 2001-2006. La democratización de la salud en México. Hacia un sistema universal de salud*, México, 2001, p. 17.

| Guiding principles | Mexican legislation | National Health Program (PNS) |
|---|---|---|
| Universality | **Article 4° of the Constitution**: "All persons are entitled to health protection".<br><br>**Article 35 of the General Bill of Health**: "Public services to the population in general are those that are granted in public health institutions to the inhabitants of the country that require them, based on the criteria of universality and costfreeness, founded on the socioeconomic conditions of the users. | **Strategy 5: To offer financial protection regarding health to the whole population**: Consolidate basic protection and promote universal and equitable insurance, in order to guarantee that in 2006 the whole population will be covered; promote and extend the affiliation to social security (schemes of voluntary affiliation to social security directed towards people working in the sector of informal economy, as well as to families with payment capacity); order and regulate private insurance as a complementary measure. |
| Progressive realization | **Article 25 of the General Bill of Health:** "According to the priorities of the National Health System, quantitative and qualitative extension of health services ought to be guaranteed, preferably to vulnerable groups". | **Strategy 5: To offer financial protection regarding health to the whole population:** To advance in the geographic extension and the integral character of health attention (extension of services to marginalized communities that currently lack attention; improved first level health services). |
| Non discrimination and equity | **Article 1° of the Constitution:** "all forms of discrimination, motivated by ethnic or national origin, gender, age, handicapped status, social condition, health condition, religion, opinions, preferences, civil status or any other that attempts against human dignity and has for object to undermine or to impair the rights and liberties of the people are forbidden."<br><br>**Article 25 of the General Bill of Health:** "According to the priorities of the National Health System, quantitative and qualitative extension of health services ought to be guaranteed, preferably to vulnerable groups". | **Strategy 1**: **To link health with economic and social development**: To promote a gender perspective in the health sector (to create conscience about the special needs of women; to reduce inequities; to improve the quality of attention; to strengthen the financial protection of women regarding health).<br>**Strategy 2**: **To reduce the existing gaps in health that affect the poor**: To improve health and nutrition of indigenous communities (educational communication in health and nutrition; training doctors, nurses and community personnel with a cross-cultural approach).<br>**Strategy 5: To offer financial protection regarding health to the whole population**: Consolidate basic protection and promote universal and equitable insurance, in order to guarantee that in 2006 the whole population will be covered; promote and extend the affiliation to social security (schemes of voluntary affiliation to social security directed towards people working in the sector of informal economy, as well as to families with payment capacity); order and regulate private insurance as a complementary measure. |

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|---|---|---|
| | | **Strategy 6**: **To build towards a cooperative federalism in regard to health**: Definition of explicit criteria for the allocation of the global budget of investment, in such a way that it reflects the needs of infrastructure; budgeting mechanisms or payment in the decentralized institutions, consistent with the demand. |
| Accessibility | **Article 35 of the General Bill of Health**: "Public services to the population in general are those that are granted in public health institutions to the inhabitants of the country that require them, based on the criteria of universality and costfreeness, founded on the socioeconomic conditions of the users.<br>**Article 25 of the General Bill of Health:** "According to the priorities of the National Health System, quantitative and qualitative extension of health services ought to be guaranteed, preferably to vulnerable groups". | **Strategy 5: To offer financial protection regarding health to the whole population**: Consolidate basic protection and promote universal and equitable insurance, in order to guarantee that in 2006 the whole population will be covered; promote and extend the affiliation to social security (schemes of voluntary affiliation to social security directed towards people working in the sector of informal economy, as well as to families with payment capacity); order and regulate private insurance as a complementary measure.<br>**Strategy 6**: **To build towards a cooperative federalism in regard to health**: Definition of explicit criteria for the allocation of the global budget of investment, in such a way that it reflects the needs of infrastructure; budgeting mechanisms or payment in the decentralized institutions, consistent with the demand. |
| Costfreeness | **Article 35 of the General Bill of Health**: "Public services to the population in general are those that are granted in public health institutions to the inhabitants of the country that require them, based on the criteria of universality and costfreeness, founded on the socioeconomic conditions of the users.<br><br>**Article 36 of the General Bill of Health**: "The recovery quotas (user fees) that are collected for the provision of health services, will be determined in accordance with the fiscal legislation and the coordination agreements that take place between the Federal government and the States. The recovery quotas will be determined taking into account the cost of the services provided and the user's socioeconomic condition. The recovery quotas will be founded on principles of social solidarity and keep relationship with the income of the users, exempting those who cannot afford to pay them, or in the areas of less economic and social development, according to the dispositions of the Ministry of Health". | |

| | | |
|---|---|---|
| Availability | **Article 23 of the General Bill of Health**: "For effects of this law, health services are understood as all those actions carried out in benefit of the individual and society in general, aimed at protecting, promoting and restoring the health of the person and of the collective."<br><br>**Article 2 of the General Bill of Health**: The right to the protection of health has the following purposes: "The enjoyment of health and social assistance services that satisfy effective and appropriately the needs of the population."<br><br>**Article 3 of the General Bill of Health**: It is matter of general health: "The organization, coordination and surveillance of professional, technical and auxiliary activities for the provision of health; as well as the constitution of human resources for."<br><br>**Article 29 of the General Bill of Health**: "Of the basic list of inputs of the health sector, the Ministry of Health will determine the list of medications and other essential inputs for health, and it will guarantee its permanent existence and availability to the population that requires them". | **Strategy 6**: **To build towards a cooperative federalism in regard to health**: Definition of explicit criteria for the allocation of the global budget of investment, in such a way that it reflects the needs of infrastructure; budgeting mechanisms or payment in the decentralized institutions, consistent with the demand. Establishment of new mechanisms for the equitable allocation of resources, especially regarding the formula for the distribution of FASSA.<br>**Strategy 7**: **To strengthen the directing role of the Ministry of Health**: To reinforce the accessibility and reasoned consumption of medications. Supply of essential medications and prescriptions in the units of first level of attention. |
| Quality | **Article 6 of the General Bill of Health**: The national system of health has the following objectives: "To provide health services to the whole population and to improve their quality, paying attention high-priority sanitary problems and those factors that condition and cause damage to health, with special interest in preventive actions". | **Strategy 4**: **To deploy a crusade for the quality of health services:** To improve quality by reducing the inequalities among States, institutions and levels of attention; guarantee the dignified treatment of users by offering timely attention and comprehensive information, as well as better opportunities for professional development to the personnel of the health sector. |

The following can be inferred from this chart:

1. All the guiding principles and characteristics identified have their equivalent in national legislation, mainly in the General Health Bill. However, the comprehensiveness with which they are approached varies in a substantial way.
    a. In some cases, such as progressive realization of the right to health—a principle specifically agreed upon in the Covenant on Economic, Social and Cultural Rights—the provision established in the General Health Bill is very explicit, making reference to the quantitative and qualitative ***extension*** of health services.
    b. In the case of equality, however, there are no clauses that explicitly recapture the prohibition of discriminatory practices in health services provided by public or private institutions.
    c. Similar omissions are present regarding access to health services.

2. Most of the guiding principles and characteristics of the right to health also find expression in the National Health Program (PNS). It is worth mentioning that, just as it happens with the General Health Bill, the PNS does not necessarily integrate the core content of the guiding principles in its components.
    a. With respect to equity it has to be celebrated that the PNS includes concrete actions designed to reduce the gaps existing among certain groups, such as the indigenous population and women.
    b. Although accessibility of health services is not broadly expressed in the strategies, it can be tacitly understood that the extension of services points in this direction.
    c. It is a matter of concern that cost free services are not contemplated among the factors that configure the principles and general ideas of the PNS, especially because some of it's proposals attempt in a direct way against this principle.

As a framework for analysis of the consistency among budget allocations and the guidelines of the right to health, as expressed in the national legislation and in the program that will regulate the actions of the government during the current administration, we will recapture two general characteristics of human rights—universality and progressive realization—and three guiding principles of the right to health: availability, accessibility, and equity.

## 5. THE NATIONAL HEALTH SYSTEM: INSTITUTIONALIZED INEQUALITY

In 1943 the Ministry of Health and Assistance was created by the merger of two institutions: the Ministry of Assistance an the Department of Health.[23] At the same time, the Mexican Social Security Institute (IMSS) was created. Later on, the Institute of Social Security and Services for Government Employees Institute (ISSSTE), the Social Security Institute for the Mexican Armed Forces (ISSFAM), and the Social Security Services of PEMEX ( which is the public corporation responsible for the management of Mexico's oil resources), were created, all of them functioning as separate entities.

This division of the healthcare system marked the formal separation of the beneficiaries of social security—employees of both the private and public sectors, and their nuclear families—and the rest of the population, mainly located in rural areas. In practice, this distinction brought about the development of a discriminatory and uneven healthcare system, and caused that by 1980, half of the population was covered by the services offered by IMSS and the ISSSTE, while the rest had to resort either to private services or to those implemented for unprotected population, generally of very poor quality. Additionally, since 1979 a program called IMSS-Coplamar began operating[24], with the purpose of reverting the marginalization of indigenous communities through first level medical services.

At the beginning of Ernesto Zedillo's term (1994-2000), 10 millions of Mexicans were still lacking access to basic health services.[25] The governments answer to this problem was to promote a reform of the sector, that included new programs and methods to transform the access to services, with the purpose of extending the coverage.[26]

As a result a familiar health insurance plan was implemented—with the purpose of extending the benefits of social security to independent employees. Also, the process of decentralization to States and municipalities continued: In 1998 a decentralized fund for health services (FASSA) was created, with the purpose of decentralizing earmarked funds for the States to manage their healthcare systems.

In 1983, the decentralization process of the health sector began, through the 1984-1988 National Health Program and the General Health Bill, both applicable to IMSS-Coplamar and the Health Ministry.* A relevant element of this process was that resources would come from the Federal government, the States, specific co-financing agreements and user fees. By increasing the flow of resources coming from the States, the allocation of resources from the Federal government stalled, instigating a slow down in investment programs—because most of the funds were used in current expenses. This points to a major weakness of the decentralization process, which retained control of decision making and normative aspects at Federal level, only decentralizing operational tasks.

* L. Flamand Gómez, *Las perspectivas del nuevo federalismo: el sector salud. Las experiencias en Aguascalientes, Guanajuato y San Luis Potosí*, México, Centro de Investigación y Docencia Económicas, División de Administración Pública, Documento de Trabajo número 55, México, 1998, p. 19.

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[23]A. Torres Ruiz, *Descentralización en salud: algunas consideraciones para el caso de México,* Centro de Investigación y Docencia Económicas, División de Administración Pública, Documento de Trabajo número 69, México, 1997, p. 10.

[24] This program was substituted ten years after by IMSS-Solidaridad and currently operates in 17 States, with federal funds.

[25] Poder Ejecutivo Federal, *Programa de Reforma del Sector Salud. 1995-2000*, México, 1995, p.15.

[26] *Ibid.,* p. 14.

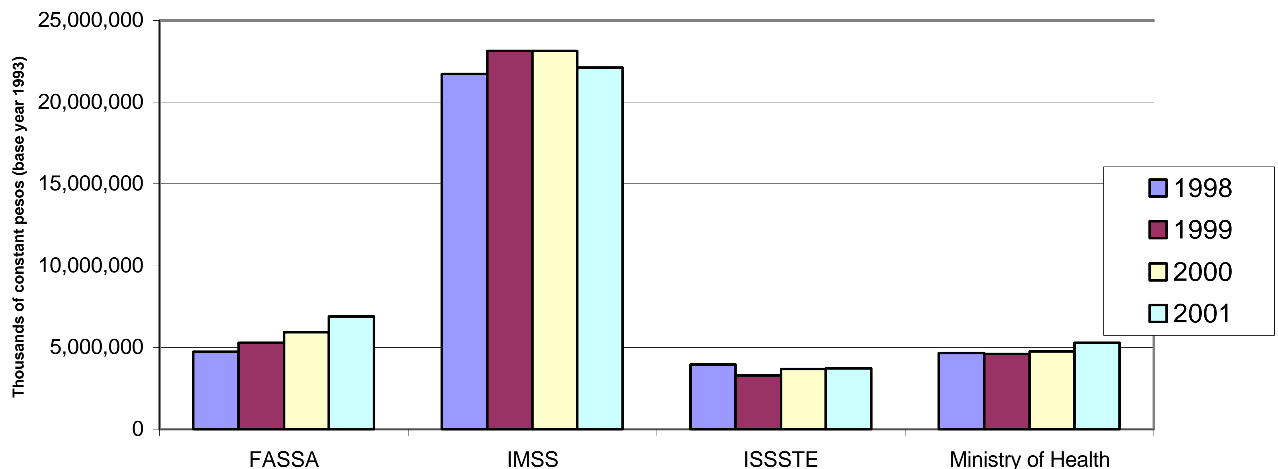
Additionally, two programs were created to meet the needs of the population living in extreme poverty: a program of basic service extension (*Programa de Ampliación de la Cobertura,* PAC) and the health related component of the Program of education, health and nutrition (*Programa de Educación, Salud y Alimentación*, PROGRESA). The purpose of these programs was to provide a basic package of health services, integrated by 13 cost efficient actions[27].

## 6. PUBLIC EXPENDITURE OF HEALTH: THE GEOGRAPHY OF INEQUITY

Public expenditure on health can be separated into at least two parts: resources allocated to address the needs of the population that is formally protected by the social security system, and resources allocated to the needs of the unprotected sectors of society. For the latest one, health services are offered by State based health systems, which are financed mainly through federal transfers of funds for this purpose (FASSA). A small proportion of these services are located within the Ministry of Health itself, which additionally dedicates part of its resources to programs oriented towards sectors living in extreme poverty.

The following figure illustrates the resources allocated to the main public health institutions of the Country. Clearly, institutions belonging to the social security system, IMSS and ISSSTE, double the resources allocated to the attention of the requirements of unprotected population.

**Figure I : Health expenditure distribution by institution (1998-2001)**

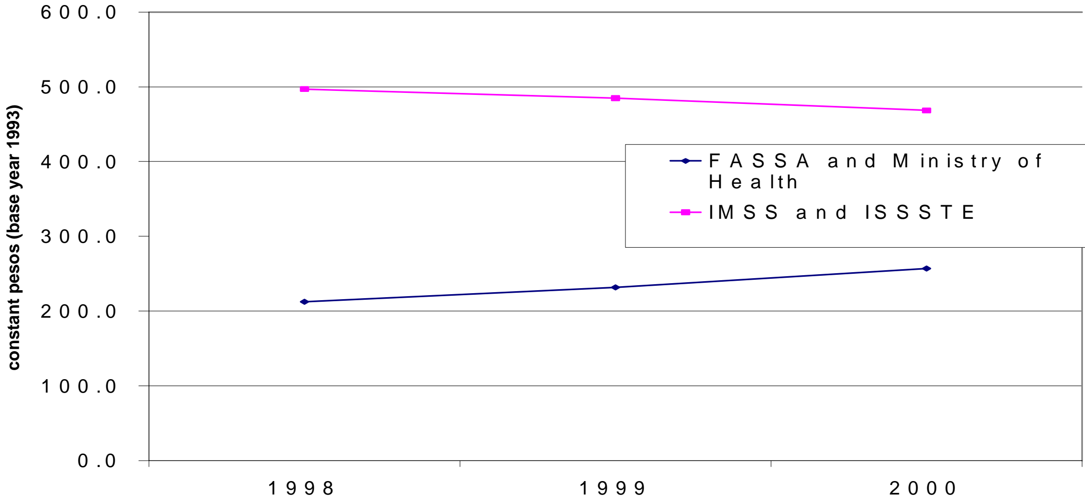



Elaborated with information of the Public Account 1998,1999 and 2000 and the Federal Budget 2001. (See table one of the annex)

[27] These actions include basic health needs at family level, family planning, prenatal, childbirth and postnatal care, as well as newborn care; nutrition and infant growth; immunization, diarrhea control, antiparasit treatment; control of acute respiratory infections; prevention and control of lung tuberculosis; prevention and control of arterial hypertension and la diabetes mellitus; prevention of accidents and management of wounds; community training for health care; prevention and detection of cervical cancer.

In 1998, per capita expenditure for sectors with access to IMSS and ISSSTE was 497.1 pesos, while its equivalent for unprotected population was less than half of it (212.7)[28]. Even though this gap diminishes during the next two years, it underscores the fact that the Mexican health system has underlying inequities, which leave those with access to social security in an initially better position. During the year 2000, for example, 71.5 per cent of the total health expenditure was destined to protected population, whereas only 28.5 percent went to the needs of unprotected population.[29]

**Figure II: Yearly per capita expenditure for protected and unprotected population**




Elaborated with information of the Public Account 1998,1999 and 2000. (See table II, annex)

This unequal distribution of resources results in a harsh distinction between protected and unprotected sectors of the population—deepening the existing differences regarding services, protection and guaranties each of these sectors have access to. The disparity in budget allocation among protected and unprotected population deepens at State level (figure III).

During 1999, total per capita expenditure on health (adding up social security and general health services) was only 595 pesos in Chiapas, while it reached 2,299 pesos in Baja California Sur. Overall, Chiapas, Oaxaca, Guerrero and Puebla had the lowest total per capita expenditure in the country, in spite of having the highest levels or marginality and unsatisfied basic needs[30]. In the southern States, where most of the indigenous people concentrate, inequalities reach their peak: mortality rate among indigenous children is 58 percent higher than elsewhere in the country. The risk of maternal death is almost three times as high for indigenous women than for women at national level. The main causes of death in these regions are still diarrhea, maternal death, tuberculosis and pneumonia.

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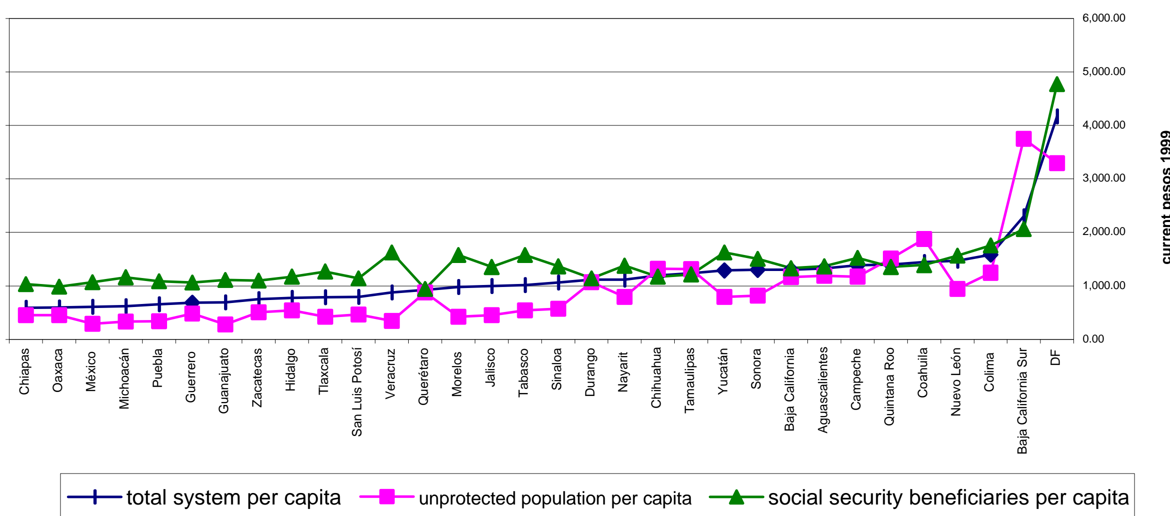
[28] Both numbers are in constant pesos of 1993.

[29] Data calculated by FUNDAR based on facts published in the Federal Public Account 2000.

[30]The Federal District was left out of this comparison. Due to the fact that the District concentrates the majority of third level attention facilities, its per capita expenditure is the highest, with 4,166 pesos.

**Figure III : State level per capita expenditure for health – 1999**




Elaborated with information of Secretaría de Salud, *La Situación de la Salud 1999*.

This gap widens even more when per capita expenditure is divided into formally protected and unprotected sectors. Only in Tamaulipas, Chihuahua, Quintana Roo and Baja California Sur, per capita expenditure of unprotected population was higher than that of those with access to the social security system. In contrast, Chiapas allocates 57 percent of its total health budget to the needs of 75 percent of its population, which lacks formal social security protection. In Oaxaca, the ratio is 56 percent of the resources for the attention of the needs of 73 percent of the population. Both States allocate approximately 450 pesos per capita to unprotected sectors yearly, while Mexico and Guanajuato only dedicate 300 pesos for each unprotected inhabitant. In Guanajuato, this allocation is equivalent to 25 percent of the allocation that benefits someone within the system of formal protection (see table III, annex).

Upon this facts, it is important to inquire about the mechanisms installed by the Health System in order to tend to the needs of those communities with lesser access to integral health care options. At the core of the PNS lies the "democratization of health", which "implies first and foremost to create the conditions to ensure that **the whole population** will have access to the corresponding assets and social services, independently from their income or the obstacles for reaching the place where they live. Health protection cannot be considered as a merchandise, object of charity, or a privilege: *It is a social right…*"[31]

> According to national accounts, "50 percent of the total health expenditure comes from private sources, and 90 percent of this expenditure comes out of the pocket… This last one tends to be greater as a percentage of the total income, in the poorest households. Conservative calculations point to the fact that each year, between two and three millions of Mexican households are forced to make use of more than a third of their available income to finance their health attention..."
>
> Source: Secretaría de Salud, *Programa Nacional de Salud 2001-2006. La democratización de la salud en México. Hacia un sistema universal de salud*, México, 2001, p.57

[31] Secretaría de Salud, *Programa Nacional de Salud 2001-2006. La democratización de la salud en México. Hacia un sistema universal de salud*, México, 2001, p. 17.

According to the PNS, the poorest sectors' access to health services will be achieved through specifically targeted programs. In theory, targeting is an answer to the urgent need of offering adequate services to the poor; in practice, however, it has implied the allocation of minimal resources that can hardly satisfy existing needs.

Overall, the Health Ministry pretends to meet the needs of the population living under conditions of extreme poverty with 6 targeted programs: PROGRESA, Even Start (*Arranque Parejo en la Vida*), Nutrition and Health for Indigenous People (*Programa de Salud y Nutrición de los Pueblos Indígenas)*, The Program of Extension of Basic Health Services (*Programa de Ampliación de Cobertura*, PAC), IMSS-Solidaridad and Popular Insurance (*Seguro Popular*). All of them have a total allocation of 9,266 million pesos for 2002, which is equivalent to 42 percent of the total resources of the Ministry.

**Table I: Budgetary allocation of targeted health programs**
**(current pesos)**

| Program | Allocation 2002 |
|---|---:|
| | |
| Even Start | 67,194,151 |
| Popular Insurance | 202,618,064 |
| PROGRESA (health component) | 3,173,600,000 |
| PAC | 1,164,913,774 |
| IMSS-Solidaridad | 4,424,633,727 |
| Health and Nutrition of Indigenous People | 233,553,896 |
| | |
| **Total** | **9,266,513,612** |

Elaborated with information from the Federal Budget 2002.

The goal of this budget is to meet the needs of 26 millions of Mexicans and by doing so, to revert some of the deepest historical and structural gaps of the country. Adding to the already evident scarcity of focalized resources to promote integral health services for those in extreme poverty, is the lack of infrastructure that characterizes these regions. This will be further analyzed in the next section.

Up to this point it is possible to say that the **progressive realization** of the right to health has been an objective of the government, at least when taking into account the constantly increasing allocation of resources—particularly those oriented towards the needs of population sectors which have no access to formal protection (granted by the social security system). Even though health service extension has been a constant goal, aiming at **universal access**, this effort has not been defined, in a meaningful way, by provisions of substantive **equity**: the distribution of public resources is characterized by high levels of inequity, since less resources are allocated to the attention of unprotected sectors, ignoring the fact that their health standard is overall lower. This situation aggravates for specific groups, such as indigenous communities and sectors living in extreme poverty.

## 7. RESOURCE ALLOCATION AND INFRASTRUCTURE FOR UNPROTECTED SECTORS: THE GAP WIDENS

The previous section shed light on the fact that the trends of spending of the divided health system upholds the disparities existing among different sectors of the population. On one hand, these trends don't contribute to closing the existing gaps: States with higher income and higher standards of health benefit of a higher per capita health spending. Even though this contributes to elevate the health standard of States with higher income, this also implies that those regions in which the most vulnerable sectors concentrate are falling behind—despite the fact that both international and national legislation recognizes that services must be specifically oriented towards them[32]. On the other hand, this inequity is accentuated by the specific distribution of resources among sectors with formal protection and those who lack of it.

Table 2 presents the ten States with the highest percentage of formally unprotected population; four of them have the highest levels of marginality at national level: Chiapas, Oaxaca, Guerrero and Veracruz.

**Table 2: Ten States with the highest percentage of formally unprotected population 1999**

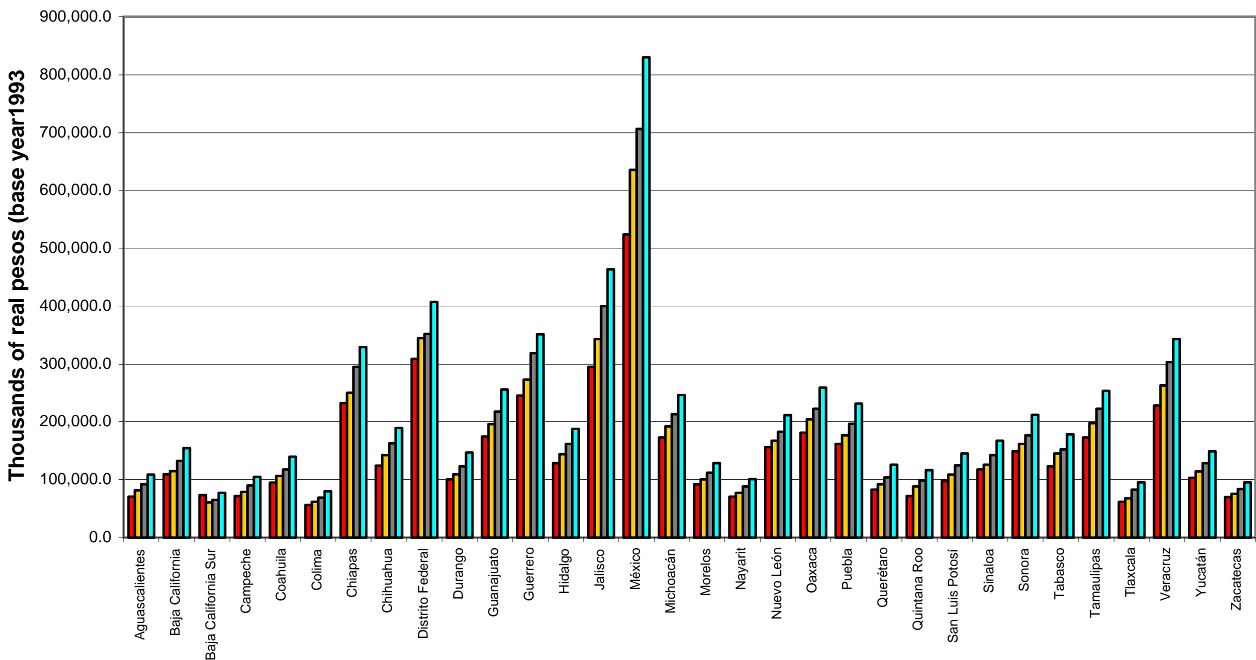
| State | Total population | Unprotected population | Protected population (social security) | Percentage of unprotected population | Level of marginality CONAPO 1995 |
|---|---|---|---|---|---|
| Chiapas | 3,994,597 | 3,015,344 | 979,253 | 75 | Very high |
| Oaxaca | 3,545,614 | 2,593,319 | 952,295 | 73 | Very high |
| Guerrero | 3,131,946 | 2,046,034 | 1,085,912 | 65 | Very high |
| Michoacán | 4,180,292 | 2,734,132 | 1,446,160 | 65 | High |
| Hidalgo | 2,281,506 | 1,434,498 | 847,008 | 63 | High |
| México | 12,833,088 | 7,583,095 | 5,249,993 | 59 | Low |
| Zacatecas | 1,430,706 | 839,650 | 591,056 | 59 | High |
| Puebla | 5,059,726 | 2,915,754 | 2,143,972 | 58 | High |
| Veracruz | 7,054,167 | 4,122,727 | 2,931,440 | 58 | Very high |
| Tlaxcala | 970,571 | 551,383 | 419,188 | 57 | Medium |

Secretaría de Salud, La Situación de la Salud, 1999, www.ssa.gob.mx (for information on all States see table IV, annex).

Part of the resources allocated by each State to health services have their origin in a decentralized fund for health services (FASSA), which is integrated with general taxes at federal level. FASSA resources are mainly used for the attention of health requirements of unprotected population. Since 1998, when FASSA was created, the trend of its resources has been one of constant and sustained growth (figure IV).

[32] See UN Committee on ESC Rights, "General Comment 14…", *op. cit.,* par. 12, and article 3 of the General Law on Health

**Figure IV: Distribution of FASSA at state level (1998-2001)**




Elaborated with information of the Public Accounts 1998,1999 and 2000 and the Federal Budget 2001 (table V of the annex presents details amounts).

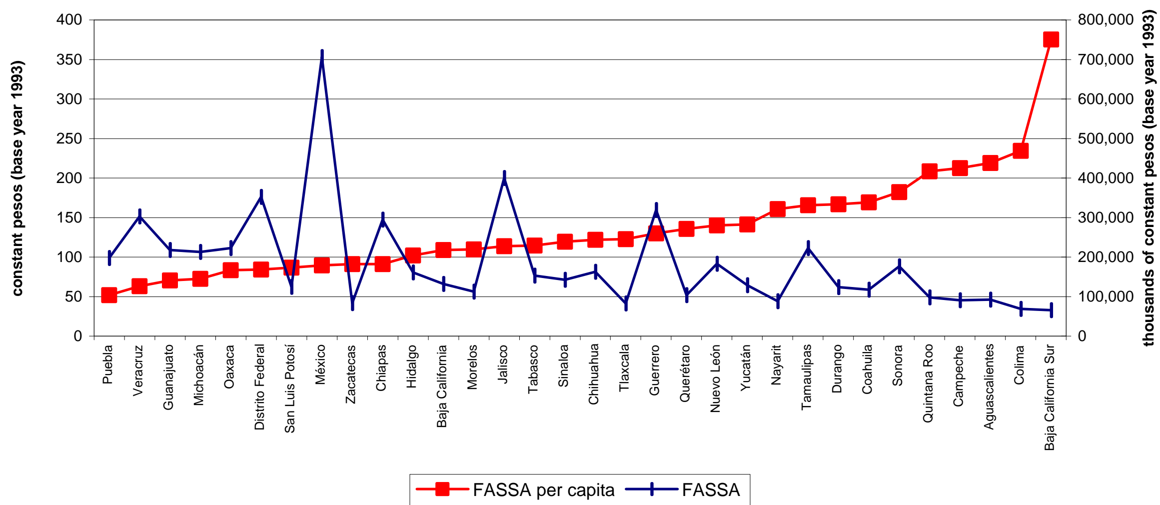
Initially, the allocation of FASSA resources seems to be consistent with the percentages of unprotected population at State level: Chiapas, Guerrero, Veracruz and Mexico receive the highest amounts, being that their unprotected population ranges from 58 to 75 percent. This initial congruency, however, diminishes when total amounts are translated into per capita spending.

According to figure V, the State of Mexico has two times more resources of FASSA than the other States of the country. Nevertheless, this State ranks among the ten States with the lowest per capita spending. Other examples are Veracruz, and Oaxaca, two of the four States with the highest levels of marginality: Veracruz stands out for having the second lowest per capita allocation at national level, while Oaxaca has less per capita spending than 27 of the 32 States in the country.

The marginality index of 1995 is built according to the following percentages: illiterate population 15 years and older; population with incomplete elementary school studies 15 years and older; families living in houses without tap water; without sewing system; without electricity; without tiled floors; overpopulated homes; population residing in communities with less than five thousand inhabitants; and working population that earns at the most two minimal wages a month (approximately 280 US dollars).

According to the marginality index, Chiapas, Guerrero, Oaxaca and Veracruz have the highest levels of marginality, in comparison to other States in the country. In those States, the percentage of the economically active population that earns at the most two minimal wages was 81.9, 75.9, 79.7 and 76.5, accordingly.

**Figure V: FASSA resources and per capita spending, by state 2000**




Elaborated with information of the Public Account 2000 and the National Health Program (see table VI, annex)

The distribution of resources among States has a direct impact on the availability of a functional health system, with adequate infrastructure, programs, skilled personnel, equipment and medicines.

To evaluate the situation of health in any given country, indicators of general death, maternal death and infant death are used, as well as main causes of illness and life expectancy. In Mexico, indicators of general death have been changing throughout the last four decades. It is a fact that post-transitional illnesses are taking the lead, while pre-transitional illnesses are still prevalent among poor and vulnerable groups.

This combination of pre- and post-transitional diseases requires sufficient infrastructure to guarantee the access to three levels of medical attention[33], a condition which is not being fulfilled.

In Mexico by 1999, the **general rate of mortality** was 4.5 deaths for every thousand inhabitants, but for the States of Puebla, Oaxaca, Mexico City, and Chihuahua the rate was above average. The main causes of death were heart diseases, malignant tumors and diabetes (these three causes of death amounted to almost 38 percent). Other causes were accidents, liver diseases and brain diseases.

The **rate of maternal death** was 5.3 for every 10 thousand born alive in 1999. The State of Guerrero had a rate of 9.6, while the States of Tabasco, Oaxaca, Morelos, Mexico, Chiapas, and Mexico City had a rate of over 6. According to the Ministry of Health, 68.3 percent of the cases are women who have no access to the social security heath system.

[33] Health services can be divided into three types: **first level attention** which includes general health, primary preventive care; **second level attention** which includes basic specialization (internal medicine, general surgery, pediatrics and gynecology), secondary preventive health (control and prevention of chronic disease complication), primary rehabilitation; **third level of attention** or of high specialization, which include secondary specialization (genetics, hematology, immunology, pediatric surgery, among others), as well as specialized laboratories. L. Flamand Gómez, *op. cit.,* p. 4.

Among the ten States with the lowest ratio of first level attention units per 100 thousand inhabitants, more than half of them are States with over 57 percent of formally unprotected population. The State of Mexico, for instance, has only 12 units per 100 thousand inhabitants; Guanajuato has 20, while Veracruz, Puebla and Chiapas don't reach a ratio of 30 units per 100 thousand inhabitants. In comparison, ten States at national level have a ratio higher than 60 first level attention units, none of which have high levels of marginality. Baja California Sur concentrates more than 140 units per 100 thousand inhabitants.

The **child mortality rate** was 14.5 for every one thousand born alive in 1999. The State of Tlaxcala had the highest rate (25.4), while Puebla and Mexico reported rates over 20. The main causes of child death were respiratory infections and diarrhea, both related to the availability of health services, and to conditions of marginality and health.

Source: Secretaría de Salud, *La situación de la salud 1999*, www.ssa.gob.mx

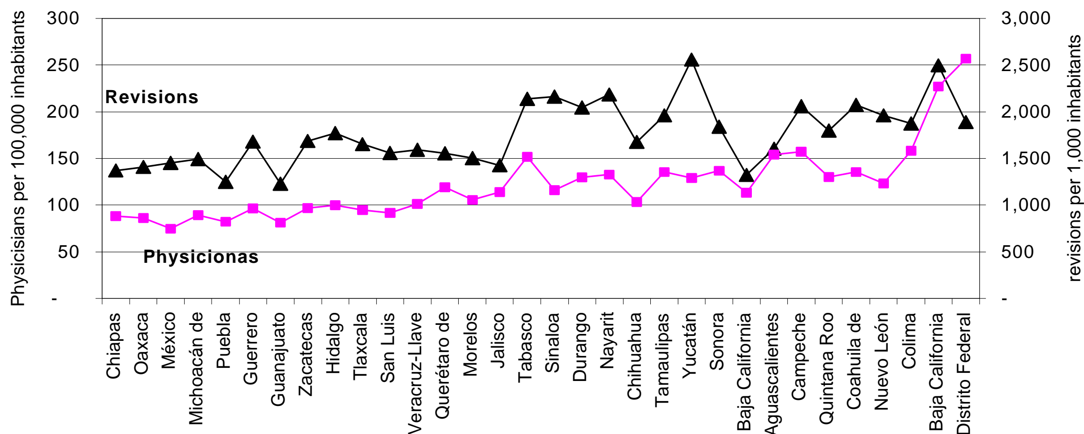
The distribution of general hospitals, which compose the second level of attention, also leaves behind those States with the highest percentage of unprotected population: 8 out of 10 have less than one unit per 100 thousand inhabitants, while the remaining two are above one unit, by a narrow margin (table VII, annex). The geographical distribution of third level attention facilities, specialized medical hospitals and investigation centers, which are fundamental to deal with the epidemical transition the country is going through, is even more unequal. Six States at national level don't have a single third level unit, among which are Chiapas, Guerrero and Zacatecas (see table VII, annex).

Looking at the dispersion of the three levels of health facilities for unprotected population, it has to be mentioned that third level hospitals concentrate at the Federal District, the country's capital city, which has 41 units in total. This situation implies a problem of accessibility to the population of the rest of the country. This excessive concentration is not the case for second level attention units, nor for external revisions, which offer minimal medical attention to unprotected sectors[34].

Another problem related to the facilities, is the number of physicians per inhabitants. The States with the highest levels of marginality have less than 100 physicians per 100 thousand inhabitants, a ration which is topped in more than a half by the Federal District, Baja California Sur, Colima, Campeche, Aguascalientes and Tabasco. (Figure VI)

[34] The States with more units of external medicine for unprotected population are Veracruz (1,068), Oaxaca (1,039), Guerrero (961), México (956), Chiapas (873) and Puebla (767).

**Figure VI: Attention indicators, by State**
**(in the order of per capita budget for health)**




Elaborated with information of the Instituto Nacional de Estadística Geografía e Informática, “Recursos y Servicios: estadísticas sociodemográficas”, *Boletín de Información Estadística* núm. 19, 1999.

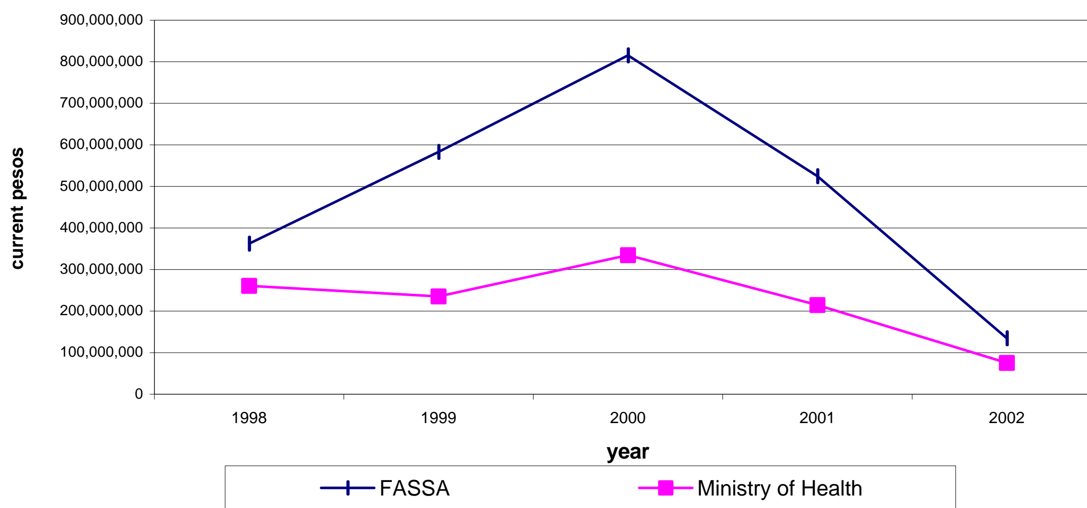
According to the geographical distribution of the three levels of attention facilities throughout the national territory, the pattern continues to be that the four States with the highest level of marginality—as well as the group of ten States with the highest percentage of unprotected population—have the less developed infrastructure. This situation finds part of its explanation in the criteria used for the allocation of FASSA, which is based upon existing infrastructure, hired personnel and operational costs of each State. Up to this point, States characterized by a budgetary deficit in relation to the “minimum acceptable level of spending on health”, only receive, in addition, the remaining of the total allocation of FASSA, after the corresponding resources for infrastructure, personnel, and operational costs have been allocated to all States.[35] It is evident that this logic of resource allocation perpetuates existing patterns of inequity.

There are little chances for reverting this pattern without substantive provisions aimed at narrowing the existing gaps between poor States and those which have been capable to develop higher standards of health. Capital investment needed for the development of infrastructure ought to be a priority, in order to extend State level capacities to deal with the needs of unprotected population.

Notwithstanding the critical situation, resources dedicated to the investment in infrastructure during the last five years have followed an inconsistent path, characterized by clearly regressive trends (figure VII).

[35] Secretaría de Salud, *Programa Nacional de Salud 2001-2006… op. cit.*, p. 125.

**Figure VII: Budget for the development of infrastructure: FASSA and Ministry of Health**




Elaborated with information of the Public Accounts 1998, 1999, 2000, the Federal Budget 2001 and 2002.

The lack of resources for infrastructure is particularly alarming in the 2002 budget. Of all 32 States, only 10 will have budget for health infrastructure. Half of the 10 States with the highest percentage of unprotected population will have no money for infrastructure during 2002: Guerrero, Hidalgo, Morelos, Oaxaca and Zacatecas (see table VIII, annex).

This section illustrates that despite of the Mexican Government's efforts striving towards the **universal access** to health services, the failure to ensure the **availability** of a functional public health system has particularly harsh impacts on the most vulnerable groups. The current patterns of resource allocation among States leaves behind those regions where the highest percentage of unprotected population concentrates. The principle of **equity** would demand that these States are allocated more resources, in order to ensure that existing gaps will be diminished and that it will be feasible to advance towards higher standards of health. Without real availability of facilities guaranteeing attention of the first, second and third level in marginalized States, the principle of **accessibility** is also being breached, since vulnerable sectors have little chances of benefiting from the services the system offers at national level. In practice, this lack of accessibility and availability has **discriminatory effects**, because it constitutes a real obstacle for the appropriate attention of the health requirements of the poorest and most vulnerable sectors of Mexican society.

## 8. SOME INITIAL CONCLUSIONS

Despite the efforts reflected in the Mexican legislation towards guaranteeing universal access to health services, the lack of availability of a functional health system, with sufficient human and material resources to effectively respond to the needs of the population, continues to be a fact. The limits imposed upon the Mexican budget in order to allocate resources differently is a serious problem that has to be acknowledged. Nevertheless, this points to the urgent need of reassessing and evaluating the country's priorities, with the purpose of putting health at the core of action, requiring immediate and sustained attention.

One of the main objectives of the current and past administrations has been to broaden access to health services through basic packages characterized by low costs and high impact. Although these measures are relevant, they can hardly be equaled to what is needed in order to provide a model of integral health services. A series of basic health programs as a means to resolve entrenched, unfulfilled needs stand out as being insufficient to improve the health conditions of the majority of the poorest sectors of the country. Targeted programs, which could contribute towards a more equitable system by focusing on the most disadvantaged, are allocated too small a part of the pie.

The historical debt of the Mexican State regarding the universal provision of access to health is far too big to be solved through six-year programs, that fail to offer a sustained, long-term solution. The National Health Program can hardly change a structural problem, such as the inequality that characterizes the division between the services offered to formally protected sectors and those who have limited access to integral services.

Furthermore, planning doesn't seem to be a product of detailed assessments of the existing inequalities—since it doesn't set forth actions specifically aimed at reducing existing gaps in the medium and long term. This situation comes as no surprise, as it is a reflection of a budget process that doesn't consider medium term objectives, and thus fails to set fiscal targets that could contribute to have the resources which are required to satisfy unfulfilled needs. Limited planning and resources, as well as a lack of clear and unquestionable priorization, reinforce each other negatively. They perpetuate a situation that clearly constitutes a breach of the right to the highest attainable standard of health, under conditions of equity and universality.

Even though it is difficult to forsee  a substantial increase of the available resources in the short run, it is urgent to move towards a set of clearly defined actions, aimed at achievable benchmarks. In this way, the reduction of existing gaps could be evaluated, and responsibility could be established in case of failure to achieve the goals agreed upon. These actions require more political will, than additional resources.

On the side of civil society, diverse strategies are required: this discussion has to be taken to Congress, which year by years gains importance as a counterweight to the Executive. Civil society has to push for a bigger piece of the pie for targeted health programs and infrastructure, particularly in the poorest States, during the approval of the budget—and before that, through the work carried out in legislative committees. Similarly, the General Health Bill has to be revised and reformed, in order to demand effective planning and benchmarking, as well as supervision, monitoring and evaluation of results by Congress and civil society.

## 9. ANNEX

**Table I: Health expenditure by institution**
**Constant pesos of 1993**

| | 1998 | 1999 | 2000 | 2001 |
|---|---|---|---|---|
| FASSA Ramo | 4,720,390.2 | 5,297,859.6 | 5,939,348.4 | 6,887,072.0 |
| Health Ministry | 4,657,590.8 | 4,613,028.6 | 4,756,729.1 | 5,280,217.1 |
| IMSS | 21,747,146.1 | 23,125,505.1 | 23,136,996.4 | 22,140,718.1 |
| ISSSTE | 3,936,265.4 | 3,283,633.1 | 3,671,957.5 | 3,705,057.3 |

Elaborated with information of the Public Accounts 1998, 1999 y 2000 and the Federal Budget 2001.

**Table II: Yearly per capita expenditure for protected and unprotected population**
**Constant pesos of 1993**

| | 1998 | 1999 | 2000 |
|---|---|---|---|
| FASSA + Ministry of Health | 212.66 | 231.92 | 256.87 |
| IMSS e ISSSTE | 497.10 | 484.97 | 468.35 |

Elaborated with information of the Public Accounts 1998, 1999 y 2000.

**Table III: State level per capita expenditure for health – 1999**
**Current pesos of 1999**

| State | Per capita allocation total population | Per capita allocation unprotected population | Per capita allocation protected population |
|---|---|---|---|
| Aguascalientes | 1,321.01 | 1,189.38 | 1,363.22 |
| Baja California | 1,302.37 | 1,169.77 | 1,327.66 |
| Baja California Sur | 2,299.23 | 3,750.96 | 2,060.72 |
| Campeche | 1,383.11 | 1,171.11 | 1,522.83 |
| Chiapas | 595.65 | 452.73 | 1,035.72 |
| Chihuahua | 1,199.17 | 1,315.37 | 1,175.96 |
| Coahuila | 1,441.60 | 1,875.58 | 1,392.21 |
| Colima | 1,579.71 | 1,246.63 | 1,754.64 |
| DF | 4,166.53 | 3,294.39 | 4,774.70 |
| Durango | 1,117.65 | 1,068.90 | 1,141.69 |
| Guanajuato | 692.16 | 281.45 | 1,114.39 |
| Guerrero | 685.81 | 484.06 | 1,065.93 |
| Hidalgo | 779.43 | 545.41 | 1,175.78 |
| Jalisco | 1,002.72 | 455.00 | 1,356.14 |
| México | 611.46 | 292.69 | 1,071.88 |
| Michoacán | 620.13 | 332.55 | 1,163.82 |
| Morelos | 979.61 | 423.96 | 1,577.37 |
| Nayarit | 1,121.29 | 797.56 | 1,375.54 |
| Nuevo León | 1,465.33 | 945.06 | 1,563.06 |
| Oaxaca | 597.87 | 455.56 | 985.43 |
| Puebla | 658.01 | 341.31 | 1,088.70 |
| Querétaro | 928.85 | 878.79 | 948.62 |
| Quintana Roo | 1,392.71 | 1,507.61 | 1,354.32 |
| San Luis Potosí | 799.30 | 467.44 | 1,142.11 |
| Sinaloa | 1,066.37 | 575.06 | 1,362.91 |
| Sonora | 1,299.89 | 823.18 | 1,502.09 |
| Tabasco | 1,020.15 | 546.32 | 1,574.73 |
| Tamaulipas | 1,238.10 | 1,311.56 | 1,218.41 |
| Tlaxcala | 790.66 | 426.74 | 1,269.35 |
| Veracruz | 877.25 | 346.76 | 1,623.33 |
| Yucatán | 1,286.18 | 799.16 | 1,624.21 |
| Zacatecas | 753.57 | 506.93 | 1,103.93 |

Elaborated with information of Secretaría de Salud, La Situación de la Salud 1999, www.ssa.gob.mx

**Table IV: Health protection at State level - 1999**

| State | Total population | Unprotected population | Protected population | Percentage of unprotected population | Level of marginality CONAPO 1995 |
|---|---|---|---|---|---|
| Chiapas | 3,994,597 | 3,015,344 | 979,253 | 75 | Muy alto |
| Oaxaca | 3,545,614 | 2,593,319 | 952,295 | 73 | Muy alto |
| Michoacán | 4,180,292 | 2,734,132 | 1,446,160 | 65 | Alto |
| Guerrero | 3,131,946 | 2,046,034 | 1,085,912 | 65 | Muy alto |
| Hidalgo | 2,281,506 | 1,434,498 | 847,008 | 63 | Alto |
| México | 12,833,088 | 7,583,095 | 5,249,993 | 59 | Bajo |
| Zacatecas | 1,430,706 | 839,650 | 591,056 | 59 | Alto |
| Veracruz | 7,054,167 | 4,122,727 | 2,931,440 | 58 | Muy alto |
| Puebla | 5,059,726 | 2,915,754 | 2,143,972 | 58 | Alto |
| Tlaxcala | 970,571 | 551,383 | 419,188 | 57 | Medio |
| Tabasco | 1,904,677 | 1,027,116 | 877,561 | 54 | Alto |
| Morelos | 1,559,983 | 808,469 | 751,514 | 52 | Bajo |
| San Luis Potosí | 2,380,966 | 1,209,803 | 1,171,163 | 51 | Alto |
| Guanajuato | 4,815,139 | 2,440,877 | 2,374,262 | 51 | Medio |
| Nayarit | 949,177 | 417,533 | 531,644 | 44 | Medio |
| DF | 8,765,285 | 3,601,157 | 5,164,128 | 41 | Muy bajo |
| Yucatán | 1,653,004 | 677,247 | 975,757 | 41 | Alto |
| Campeche | 696,752 | 276,786 | 419,966 | 40 | Alto |
| Jalisco | 6,425,723 | 2,520,091 | 3,905,632 | 39 | Bajo |
| Sinaloa | 2,487,954 | 936,449 | 1,551,505 | 38 | Medio |
| Colima | 533,212 | 183,614 | 349,598 | 34 | Bajo |
| Durango | 1,519,048 | 501,795 | 1,017,253 | 33 | Medio |
| Sonora | 2,215,207 | 659,768 | 1,555,439 | 30 | Bajo |
| Querétaro | 1,384,774 | 392,034 | 992,740 | 28 | Medio |
| Quintana Roo | 793,314 | 198,683 | 594,631 | 25 | Medio |
| Aguascalientes | 963,711 | 234,018 | 729,693 | 24 | Muy bajo |
| Tamaulipas | 2,698,875 | 570,443 | 2,128,432 | 21 | Bajo |
| Chihuahua | 3,013,272 | 501,821 | 2,511,451 | 17 | Bajo |
| Baja California | 2,329,685 | 373,253 | 1,956,432 | 16 | Muy bajo |
| Nuevo León | 3,809,714 | 602,457 | 3,207,257 | 16 | Muy bajo |
| Baja California Sur | 399,180 | 56,329 | 342,851 | 14 | Bajo |
| Coahuila | 2,351,553 | 240,296 | 2,111,257 | 10 | Muy bajo |

Elaborated with information of Secretaría de Salud, La Situación de la Salud, 1999, www.ssa.gob.mx

Muy alto = Very high
Alto = High
Medio = Medium
Bajo = Low
Muy Bajo = Very low

**Table V: Distribution of FASSA at State level 1998-2001**
**Thousands of constant pesos 1993**

| | Spent | Spent | Spent | Approved |
|---|---|---|---|---|
| **Estado** | **1998** | **1999** | **2000** | **2001** |
| Aguascalientes | 71,002.7 | 81,615.4 | 92,306.1 | 108,702.8 |
| Baja California | 109,175.9 | 115,160.4 | 132,099.1 | 154,774.2 |
| Baja California Sur | 73,882.5 | 60,226.1 | 65,409.6 | 77,324.0 |
| Campeche | 71,439.1 | 79,444.7 | 90,499.2 | 104,982.8 |
| Coahuila | 94,444.8 | 106,745.1 | 117,719.7 | 139,586.9 |
| Colima | 56,130.6 | 61,493.3 | 69,205.5 | 79,993.6 |
| Chiapas | 232,940.4 | 249,879.5 | 294,838.3 | 329,312.1 |
| Chihuahua | 124,029.1 | 142,491.8 | 162,697.5 | 189,541.3 |
| Distrito Federal | 309,343.0 | 344,441.1 | 352,099.3 | 406,794.2 |
| Durango | 100,253.8 | 109,672.2 | 123,616.3 | 147,216.1 |
| Guanajuato | 174,992.0 | 196,156.8 | 217,735.1 | 255,963.4 |
| Guerrero | 245,080.0 | 272,814.5 | 318,995.9 | 350,814.9 |
| Hidalgo | 128,331.1 | 143,925.5 | 161,467.4 | 187,884.3 |
| Jalisco | 294,911.0 | 342,989.6 | 400,156.5 | 463,641.1 |
| México | 523,971.5 | 635,031.5 | 705,819.2 | 829,848.5 |
| Michoacán | 172,655.7 | 191,829.2 | 212,916.5 | 246,303.7 |
| Morelos | 92,079.5 | 100,444.6 | 112,199.8 | 128,318.3 |
| Nayarit | 70,879.8 | 77,067.5 | 87,895.4 | 101,321.7 |
| Nuevo León | 155,944.8 | 167,084.3 | 183,113.3 | 211,724.9 |
| Oaxaca | 180,657.8 | 204,359.3 | 222,463.7 | 259,531.6 |
| Puebla | 161,692.7 | 176,333.7 | 197,171.9 | 231,213.0 |
| Querétaro | 82,672.8 | 91,963.1 | 103,874.5 | 125,635.5 |
| Quintana Roo | 72,121.7 | 88,365.3 | 98,170.4 | 117,154.9 |
| San Luis Potosí | 97,151.3 | 108,530.5 | 124,954.0 | 145,302.5 |
| Sinaloa | 117,293.8 | 125,740.4 | 142,224.9 | 167,443.5 |
| Sonora | 149,378.3 | 161,726.8 | 176,240.7 | 212,209.2 |
| Tabasco | 123,347.6 | 144,972.3 | 152,913.2 | 178,661.8 |
| Tamaulipas | 172,421.1 | 197,802.6 | 222,466.2 | 253,666.2 |
| Tlaxcala | 61,419.0 | 67,774.3 | 82,944.5 | 95,192.0 |
| Veracruz | 228,257.8 | 262,988.3 | 302,925.6 | 342,882.7 |
| Yucatán | 103,052.0 | 113,744.1 | 128,756.1 | 148,904.1 |
| Zacatecas | 69,436.8 | 75,045.5 | 83,452.9 | 95,226.2 |
| **Total** | **4,720,390.2** | **5,297,859.6** | **5,939,348.4** | **6,887,072.0** |

Elaborated with information of Public Accounts 1998,1999 y 2000 and the Federal Budget 2001.

**Table VI: FASSA resources and per capita spending, by State (2000)**

| Estados | Approved a/ | per capita FASSA b/ |
|---|---|---|
| Aguascalientes | 92,306.1 | 219.2 |
| Baja California | 132,099.1 | 108.8 |
| Baja California Sur | 65,409.6 | 375.3 |
| Campeche | 90,499.2 | 212.7 |
| Chiapas | 294,838.3 | 91.3 |
| Chihuahua | 162,697.5 | 121.7 |
| Coahuila | 117,719.7 | 169.1 |
| Colima | 69,205.5 | 234.4 |
| Distrito Federal | 352,099.3 | 84.0 |
| Durango | 123,616.3 | 167.0 |
| Guanajuato | 217,735.1 | 70.6 |
| Guerrero | 318,995.9 | 130.0 |
| Hidalgo | 161,467.4 | 101.9 |
| Jalisco | 400,156.5 | 113.6 |
| México | 705,819.2 | 89.4 |
| Michoacán | 212,916.5 | 72.4 |
| Morelos | 112,199.8 | 109.6 |
| Nayarit | 87,895.4 | 160.5 |
| Nuevo León | 183,113.3 | 140.1 |
| Oaxaca | 222,463.7 | 83.6 |
| Puebla | 197,171.9 | 51.7 |
| Querétaro | 103,874.5 | 135.5 |
| Quintana Roo | 98,170.4 | 208.5 |
| San Luis Potosí | 124,954.0 | 86.8 |
| Sinaloa | 142,224.9 | 119.3 |
| Sonora | 176,240.7 | 182.3 |
| Tabasco | 152,913.2 | 114.5 |
| Tamaulipas | 222,466.2 | 165.6 |
| Tlaxcala | 82,944.5 | 122.7 |
| Veracruz | 302,925.6 | 63.3 |
| Yucatán | 128,756.1 | 141.4 |
| Zacatecas | 83,452.9 | 91.2 |
| **Totales** | **5,939,348.4** | **101.8** |

a/ thousands of constant pesos 1993
b/ constant pesos of 1993
Elaborated with information of Public Account 2000 and the National Health Program 2001-2006.

**Table VII: Units of first, second and third level of attention for each 100 thousand inhabitants in 1999**

| | Ratio of units for each 100 thousand inhabitants of unprotected population | | |
|---|---|---|---|
| **State** | **First level** | **Second level** | **Third level** |
| Aguascalientes | 33.8 | 1.7 | 1.3 |
| Baja California | 34.0 | 1.1 | 0.0 |
| Baja California Sur | 145.6 | 7.1 | 3.6 |
| Campeche | 61.4 | 3.6 | 0.7 |
| Chiapas | 29.0 | 0.8 | 0.0 |
| Chihuahua | 80.9 | 3.6 | 0.8 |
| Coahuila | 105.7 | 6.7 | 2.5 |
| Colima | 63.7 | 2.2 | 0.0 |
| DF | 9.1 | 0.3 | 1.1 |
| Durango | 69.0 | 2.0 | 0.2 |
| Guanajuato | 20.2 | 0.5 | 0.1 |
| Guerrero | 47.0 | 0.7 | 0.0 |
| Hidalgo | 42.9 | 1.0 | 0.1 |
| Jalisco | 28.1 | 0.8 | 0.2 |
| México | 12.6 | 0.4 | 0.1 |
| Michoacán | 26.5 | 0.7 | 0.1 |
| Morelos | 25.9 | 0.6 | 0.1 |
| Nayarit | 66.3 | 1.4 | 0.0 |
| Nuevo León | 72.7 | 1.2 | 0.5 |
| Oaxaca | 40.1 | 0.8 | 0.0 |
| Puebla | 26.3 | 1.0 | 0.0 |
| Querétaro | 59.4 | 1.0 | 0.3 |
| Quintana Roo | 81.0 | 2.0 | 0.5 |
| San Luis Potosí | 38.0 | 0.7 | 0.2 |
| Sinaloa | 34.7 | 1.1 | 0.1 |
| Sonora | 35.5 | 2.3 | 0.5 |
| Tabasco | 47.9 | 1.3 | 0.2 |
| Tamaulipas | 62.4 | 2.6 | 0.4 |
| Tlaxcala | 31.0 | 0.7 | 0.2 |
| Veracruz | 25.9 | 0.8 | 0.1 |
| Yucatán | 34.7 | 1.0 | 0.3 |
| Zacatecas | 35.5 | 1.0 | 0.0 |

Elaborated with information of Secretaría de Salud, La Situación de la Salud, 1999, www.ssa.gob.mx

**Table VIII: Budget allocated to the development of infrastructure: FASSA and Ministry of Health Current pesos**

| | 1998 | 1999 | 2000 | 2001 | 2002 |
|---|---|---|---|---|---|
| FASSA | 362,064,400 | 582,805,100 | 815,622,000 | 524,500,000 | 134,566,128 |
| Ministry of Health | 260,806,600 | 235,194,400 | 334,948,900 | 214,236,100 | 75,696,649 |

Elaborated with information of Public Accounts 1998, 1999, 2000, the Federal Budget 2001 and 2002.

**Table IX: Federal expenditure on basic infrastructure and public investment**
**Thousand of current pesos**

| | 1998 a/ | 1999 b/ | 2000 b/ | 2001 b/ | 2002 a/ |
|---|---|---|---|---|---|
| Aguascalientes | 4,714.8 | 9,777.7 | 8,194.7 | 7,850.2 | 0.0 |
| Baja California | 12,536.0 | 17,324.8 | 22,824.2 | 13,161.5 | 0.0 |
| Baja California Sur | 6,090.8 | 8,098.1 | 13,940.3 | 4,652.3 | 0.0 |
| Campeche | 6,144.8 | 8,331.5 | 10,573.2 | 5,566.4 | 2,388.3 |
| Coahuila | 17,389.6 | 6,228.4 | 8,175.0 | 8,017.0 | 48.6 |
| Colima | 28,450.0 | 22,749.6 | 92,074.0 | 4,270.4 | 0.0 |
| Chiapas | 33,326.7 | 38,012.7 | 48,253.9 | 25,044.0 | 250.7 |
| Chihuahua | 10,476.8 | 13,519.5 | 15,200.3 | 22,049.0 | 14,381.4 |
| DF | 7,147.3 | 7,761.0 | 11,341.5 | 20,560.0 | 4,256.4 |
| Durango | 12,024.4 | 18,917.4 | 12,944.3 | 13,656.0 | 0.0 |
| Guanajuato | 17,153.6 | 27,941.3 | 69,009.6 | 16,737.2 | 0.0 |
| Guerrero | 23,975.2 | 32,985.1 | 52,703.9 | 20,051.4 | 0.0 |
| Hidalgo | 13,203.7 | 29,374.6 | 32,290.4 | 17,358.7 | 0.0 |
| Jalisco | 5,987.6 | 13,681.9 | 26,597.0 | 27,891.3 | 0.0 |
| México | 15,504.8 | 63,521.8 | 64,769.5 | 89,640.7 | 19,696.1 |
| Michoacán | 12,018.0 | 32,502.3 | 27,643.3 | 24,969.8 | 40,367.5 |
| Morelos | 7,135.5 | 9,419.4 | 5,129.5 | 6,734.9 | 0.0 |
| Nayarit | 4,954.4 | 6,941.1 | 10,888.1 | 6,138.7 | 0.0 |
| Nuevo León | 8,542.4 | 15,452.6 | 7,277.3 | 15,680.0 | 0.0 |
| Oaxaca | 15,016.4 | 20,378.3 | 57,760.0 | 17,024.0 | 0.0 |
| Puebla | 6,087.2 | 28,633.4 | 24,357.4 | 34,977.6 | 8,277.2 |
| Querétaro | 5,204.8 | 21,582.2 | 35,565.9 | 24,671.5 | 0.0 |
| Quintana Roo | 4,031.6 | 5,584.0 | 9,352.7 | 5,750.5 | 0.0 |
| San Luis Potosí | 6,006.4 | 10,150.3 | 15,335.3 | 14,728.0 | 0.0 |
| Sinaloa | 9,524.4 | 14,672.3 | 12,873.6 | 16,776.5 | 0.0 |
| Sonora | 10,953.6 | 12,770.5 | 7,297.2 | 18,344.1 | 0.0 |
| Tabasco | 20,960.4 | 36,804.7 | 31,678.3 | 9,655.4 | 0.0 |
| Tamaulipas | 9,966.0 | 11,490.5 | 16,819.4 | 10,744.5 | 0.0 |
| Tlaxcala | 4,501.6 | 9,966.8 | 6,349.1 | 6,406.0 | 9,312.0 |
| Veracruz | 8,004.8 | 42,132.3 | 61,204.1 | 24,899.0 | 35,587.4 |
| Yucatán | 9,024.4 | 18,941.7 | 18,645.3 | 8,361.8 | 0.0 |
| Zacatecas | 6,006.4 | 18,618.6 | 15,589.1 | 6,392.3 | 0.0 |
| **Total** | **362,064.4** | **634,266.4** | **852,657.4** | **548,760.5** | **134,566.1** |

a/ Only includes FASSA
b/ Includes FASSA and State level investment with PAC
Elaborated with information of Public Accounts 1998, 1999, 2000, the Federal Budget 2001 and 2002.

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