ELECTIVE (SSC5b) REPORT (1200 words)

A report that addresses the above four objectives should be written below. Your Elective supervisor will assess this.

Mexico Healthcare System

Seguro Popular

Set up in 2002, Seguro Popular is open for registration to those who cannot otherwise afford medical care, i.e. the unemployed and those not in formal employment. Although registration is required, fees are means tested, with the poorest covered free of charge. Benefits include access to primary level medical care including first level medications, referral to specialists, and a number of surgical interventions. Importantly, all women receive full access to medical care during and after pregnancy, including their newborn.

Semi- Private Health Insurance

Mexicans in formal employment can opt in to receive semi-private health insurance for themselves and their immediate family. It is financed in three parts: by the State, the employer and the employee. The institute available depends on the individual's profession - IMSS, ISSSTE, SEDENA, MARINA and PEMEX are the biggest insurers.

Private Healthcare

For those who can afford it, there are private health insurance companies. Many Mexicans also pay Out-Of-Pocket for health care as and when needed.

UK Public Healthcare

The National Health Service is government run and free at the point of care for residents of the UK. It is free to register for primary care at a General Practice, to receive secondary care at a specialist clinic and to also receive emergency care and inpatient care at a hospital. Prescription charges apply unless exempt due to chronic illness or poverty. As in Mexico, individuals can purchase private health insurance or pay OOP for healthcare if they can afford to do so.

Maternal Mortality

Maternal mortality in Mexico has been steadily decreasing since 1990 (90/100,000) and now has a rate of 38/100,000 (2015). However, there is a large variation between states, with the poorest areas (Chiapas, Guerrero and Oaxaca) having the highest rates, roughly double that of the national average.

The major medical causes of maternal mortality and morbidity are: haemorrhage, pre-eclampsia/eclampsia and septic shock. Other causes include neoplasm, embolism, and abortion. All together, these causes represent 65.8% of the total maternal deaths.

Maternal mortality is affected by a number of social determinants of health, particularly by low socioeconomic status, poor education and indigenous ethnicity. More than half of the population of Oaxaca, Mexico, including the majority of indigenous populations, live in rural areas and are subject to numerous health challenges, leading to high maternal mortality rates. There is great inequality between the rich and the poor. Women who suffer from pregnancy related fatalities are more likely

to be covered by Seguro Popular or to be in fact uninsured. The wealthy, who typically live in the cities, have a higher level of education and better access to health care, whereas the poor tend to reside in rural areas, where there is little investment into the educational and health systems by the government.

Rural, isolated communities that do not have regular access to healthcare rely heavily on traditional midwives, or parteras, to manage pregnancy and the general health of themother and her family. They are well respected members of the community and typically use different foods, herbs, oils, teas and Mezcal to treat a range of sickness. These women therefore receive less antenatal monitoring and are at an increased risk of having undiagnosed comorbidities and complications during pregnancy and birth, increasing their risk of maternal morbidity or mortality. To combat this, many rural clinics offer yearly training sessions to parteras on recognising and managing complications in pregnancy and labour and when to refer to trained health professionals.

Maternal age is known to influence risk of morbidity or mortality for the mother. Overall, México has a high teen birth rate (70.3 per 1000 women, 2013). Not only does this rate vary between states but also differs between rural and urban settings, with fewer young urban women in giving birth below the age of 18 years compared to their rural counterparts. Many women have an unmet need for contraception, most clearly seen in sexually active unmarried young women, with only around 35% using contraception. Access to contraception seems to influence levels of maternal mortality, as their use can reduce pregnancy at extreme ages, prevent accidental pregnancies and widen spacing between pregnancies. Women who have children at a slightly older age, when they are more likely to have a higher level of education and economic income, are at a lower risk of maternal mortality and morbidity.

Public health initiatives

In 1997, the Mexican government developed the 'Programa Oportunidades', now known as Prospera, aimed at improving the lives of those living in extreme poverty through three main branches - nutrition, health and education. To combat malnutrition and its complications, the government provide eligible households with basic foods including fruit, vegetables and other sources of important micronutrients commonly missing from the traditional diet of the poor: rice, beans and tortillas. Specifically, it offers nutritional supplements for women through pregnancy and after birth to avoid malnutrition. However, most people do not know how to cook the food provided and much of what's offered can end up as animal food.

In order to increase access to formal healthcare in poor, rural communities, brigades travel to cut-off villages to give vaccinations and health checks. This often coexists with the 'Casa de Salud' program whereby an auxiliary - a member of the community (who isn't medically trained) - attends to the basic healthcare needs of their village, relieving the pressure on health professionals to attend to the most needy when they visit. Once again there are also problems with this 'Ampliación de Cobertura' program. Brigades don't often have enough resources to treat patients and can leave months between each visit, forcing patients to travel to nearby villages with more resources to receive frequent care and repeat medication. Many of the auxiliaries also lack the resources, time and knowledge required to adequately manage patients or to refer them for more specialised care.

Whilst these programs have been shown to reduce negative health outcomes, there is still a proportion of the population who are not registered at birth, making it is hard to reach all families that would benefit from this program, or from Seguro Popular itself.

Personal Transformation

This placement has shown me a whole different way of practicing medicine, using the little resources and technoogy available. It also highlighted to me the importance of understanding patients' cultural beliefs and incorporating this into the management e.g. parteras and herbal remedies. Although the NHS provides a much higher level of care, these discussions made me realise that there are many similarities between Mexico and UK - with an increasingly underfunded healthcare service, postcode lottery, complaints about a drop in the quality of the service. Whilst we always look to improve services and personal practice, many of our problems in the NHS would be considered minor compared to the issues faced by healthcare professionals and patients alike in Mexico. I have an even stronger appreciation for the NHS .