

The Disparity of Indigenous and Nonindigenous Groups in the Healthcare System of Mexico

May Nguyen

All around the world, indigenous groups experience a greater number of inequalities compared to their nonindigenous counterparts. This is apparent in Mexico, where indigenous groups face greater poverty, less access to social benefits, and less access to health services. The healthcare system of Mexico used to cater to the wealthier, nonindigenous population, ignoring the marginalized, disadvantaged indigenous population. There was a lack of federal attention and aid to the healthcare of indigenous groups. They experienced low-funded healthcare facilities which led to a shortage of human resources, medications, supplies, and infrastructure. This led to a lack of health services in indigenous communities. Fewer indigenous individuals had access to health coverage and benefits compared to nonindigenous individuals. Lastly, indigenous groups faced lower quality health services overall. However, Mexico has been working on decreasing the disparity gap. In 2003, the national program *Seguro Popular* was implemented to focus on providing universal health care. Mexico has also strengthened the National Register of Translators and Interpreters in indigenous languages, and several projects were created to aid in alleviating the disparity between indigenous and nonindigenous populations in relation to healthcare. An additional solution could be to incorporate more full-time, indigenous health promoters.

Keywords: indigenous, healthcare, Mexico, disparity

Introduction

Mexico visibly suffers from the problem of disparity between its indigenous and nonindigenous populations. Compared to nonindigenous groups, indigenous communities are disadvantaged when it comes to basic rights and access to services. This problem is most notable in the healthcare industry: a system which caters to nonindigenous groups while ignoring others. However, over the past two decades, Mexico has made significant progress in alleviating this disparity. In this paper, I will discuss the disparity in the healthcare system

of indigenous and nonindigenous groups in Mexico within the past two decades. I will then discuss the different ways Mexico has addressed the issue and what can be improved in the future.

| The Disparity in Mexico

The largest indigenous population in the Americas resides in Mexico. There are over 16 million indigenous people in Mexico and over 27 million people who identify as indigenous, making up over 21% of the population (Berger). Despite this substantial number, the indigenous people of Mexico still face many disparities in the healthcare system.

The first evidence of inequity is in the lack of federal attention and aid for indigenous populations. In 2011, only 1.4% of total financial resources were allocated to fund healthcare related matters for indigenous populations, which represents only about 0.1% of the GDP (Leyva-Flores et al. 4). Due to the low funding and lack of attention, it is common to find health facilities located near indigenous communities to be lacking in resources, making it difficult to provide quality health services. There are multiple accounts of medication and supply shortages, lack of infrastructure, lack of interpreters, and a dearth of full-time staff (Pelcastre-Villafuerte et al. 614, 619, 622). Furthermore, there are an average of 2.3 accredited health clinics in nonindigenous villages and only 0.4 clinics on average in indigenous villages (Ashton 19–20). There are also 273 Federal Programs and Actions for Social Development, with 40% of the 273 targeting health care, but none of them benefit indigenous communities (Leyva-Flores et al. 4).

Low funding also means that fewer healthcare facilities are built near indigenous communities, forcing individuals to travel farther just to have access to health services. A 2011 survey found that indigenous individuals travel two-and-a-half hours longer than nonindigenous individuals on average, and it costs indigenous individuals about 20 pesos more to travel to and from healthcare facilities (Ashton 20). In 2010, 24.3% of the indigenous population were not covered under Mexico's health insurance program and therefore did not have access to health services (Pelcastre-Villafuerte et al. 611). Only 12.9% were covered by a subsidiary of an institution that provides for employed individuals and their families, which is significantly less than the 33.7% of nonindigenous individuals (Pelcastre-Villafuerte et al. 611). When comparing maternal health coverage between indigenous and nonindigenous women in Mexico throughout 2008 to 2015, there has been a constant disparity between the two groups with indigenous women always lagging behind. Less than 80% of indigenous women were covered, while about 90% of nonindigenous women were covered (Paulino et al. 62). When it came to prenatal care, contraceptive use, and postnatal care, indigenous women were constantly underserved (Paulino et al. 62). About 1 out of 4 indigenous women have no access to family planning (Servan-Mori et al. 2). Many individuals are also unable to access employer-related health benefits, such as medical care, because much of the population work informal jobs (Pelcastre-Villafuerte et al. 611).

As mentioned before, the quality of health services for indigenous groups is lower than the services offered to the general public. Upon arriving at a healthcare facility, the average wait time for an indigenous individual is about seven hours, which is over three hours longer than a nonindigenous individual (Ashton 20). Language and cultural barriers can also make

it difficult for healthcare providers to provide the best quality service to indigenous patients. Oftentimes, there is no provider or interpreter that speaks the same language and dialect as the patient, making it difficult to communicate about diseases, diagnoses, and treatments. Mexico requires by law that there be an interpreter if the indigenous patient is receiving national health care, but interpreters are not always provided. There are simply not enough interpreters available, so some medical visits carry on without an interpreter. Interpreters often only speak the most common indigenous languages, ignoring less common dialects and languages (Santos and Verdín Amaro 260). Thus, the language and cultural barriers make it difficult to thoroughly communicate in a way that will provide indigenous populations with the best possible quality of service.

Mexico's Solution

In 2003, a national program called *Seguro Popular* was created to reform Mexico's healthcare system, with the goal of achieving universal health coverage. The program specifically caters to indigenous and rural populations that do not have social security to guarantee equal access to health care (Ashton 3, 5). *Seguro Popular* is still active to this day and has been making progress. From 2006 to 2012, *Seguro Popular* was able to increase coverage for indigenous individuals from 14% to 61.9% (Leyva-Flores et al. 2). *Seguro Popular* is still working to decrease the gap for indigenous populations.

In the recent 2018 presidential elections, left candidate Andrés Manuel López Obrador introduced a new political group that restructured the federal government in a way that seemingly provides more policies regarding support, recognition, and rights to the indigenous population. One of the changes involves the strengthening of the National Register of Translators and Interpreters in indigenous languages (Berger). This could help improve communication between indigenous peoples and healthcare providers, which could then help improve the quality of health services. Being able to communicate with indigenous individuals is necessary for providing the proper treatment. Also, being able to understand and incorporate the indigenous culture and traditions into the treatment plan can strengthen trust and build better connections between patients and healthcare providers.

Independent programs are being instituted to further help alleviate the disparity as well. An example of this is the construction of *Casa Materna*, which was built in Chiapas to act as a birthing house and to address the high maternal mortality rates. It incorporates traditional birth assistants as well as medically trained birth assistants. Indigenous women can give birth in the house with a traditional birth assistant, but if any issues arise, the nearby medically trained assistants are available as well (Tucker et al. 2). Thus, through these kinds of programs, more women will have access to basic maternity health services.

Conclusion

There are still many things to improve about Mexico's health system as regards indigenous communities. One improvement that still needs to be addressed is the flaw in human resources for indigenous populations. One solution could be to incorporate indigenous

health promoters as a health resource (Pelcastre-Villafuerte et al. 625–626). There is a lack of full-time health providers and interpreters. This lack of full-time health providers forces indigenous communities to wait longer than their nonindigenous counterparts to receive health services. A hospital never closes for business—neither should the smaller facilities near indigenous communities. Also, lack of interpreters makes communication very difficult, affecting the quality of healthcare. So, finding a way to incorporate health promoters that are bilingual and are trained in medicine could help provide better staffing, filling in when there are no allopathic providers, and help provide better communication with healers acting as interpreters.

When considering the numbers and the steps taken to improve the conditions for indigenous groups, sometimes we fail to see the prevalence of inequality and how disadvantaged they still are. There is still a lot of work to do to provide better care for indigenous peoples. If nothing is to be improved or done, indigenous groups will be left incredibly disadvantaged, and it will only continue being passed down from one generation to the next. It is very hard to escape the vicious cycle of inequality and lack of access to health services, so the end of disparity in access to healthcare starts with quality resources.

References

- Ashton, Helen Louise. *Does Mexico's Seguro Popular Afford Equal Healthcare Access to Indigenous Peoples?* 2012. Georgetown University, Master of Public Policy Thesis. <https://repository.library.georgetown.edu/handle/10822/557874>.
- Berger, David Nathaniel. "Indigenous World 2019: Mexico." *IWGIA*, 24 Apr. 2019, www.iwgia.org/en/mexico/3382-iw2019-mexico.html.
- Leyva-Flores, Rene Estela, et al. "Primary Health Care Utilization by the Mexican Indigenous Population: The Role of the Seguro Popular in Socially Inequitable Contexts." *PLoS ONE*, vol. 9, no. 8, 6 Aug. 2014, doi:10.1371/journal.pone.0102781.
- Paulino, Nancy Armenta, et al. "Indigenous Language and Inequitable Maternal Health Care, Guatemala, Mexico, Peru and the Plurinational State of Bolivia." *Bulletin of the World Health Organization*, vol. 97, no. 1, 31 Oct. 2019, pp. 59–67., doi:10.2471/blt.18.216184.
- Pelcastre-Villafuerte, Blanca Estela, et al. "Aging in Rural, Indigenous Communities: an Intercultural and Participatory Healthcare Approach in Mexico." *Ethnicity & Health*, vol. 22, no. 6, 28 Oct. 2016, pp. 610–630., doi:10.1080/13557858.2016.1246417.
- Santos, Saul, and Karina Verdín Amaro. "Intercultural Communication Issues during Medical Consultation: the Case of Huichol People in Mexico." *Cuadernos Interculturales*, vol. 9, no. 17, 2011, pp. 257–271. *Redalyc*, <https://www.redalyc.org/articulo.oa?id=55222591016>.
- Servan-Mori, Edson, et al. "An Explanatory Analysis of Economic and Health Inequality Changes among Mexican Indigenous People, 2000-2010." *International Journal for Equity in Health*, vol. 13, no. 21, 27 Feb. 2014, doi:10.1186/1475-9276-13-21.
- Tucker, Kathryn, et al. "The Acceptability and Feasibility of an Intercultural Birth Center in the Highlands of Chiapas, Mexico." *BMC Pregnancy and Childbirth*, vol. 13, no. 94, 16 Apr. 2013, doi:10.1186/1471-2393-13-94.

