Title: Navigating and Circumventing a Fragmented Health System: The Patient’s Pathway in the Sierra Madre Region of Chiapas, Mexico
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Mexico has implemented several important reforms in how health care for its poorest citizens is financed and delivered. Seguro Popular, in particular, is a recently implemented social insurance program that aims to provide new funds for a previously underfunded state-based safety net system. Through in-depth ethnographic structured interviews with impoverished farmers in the state of Chiapas, this article presents an analysis of Seguro Popular from the perspective of a highly underserved beneficiary group. Specific points of tension among the various stakeholders—the government system (including public clinics, hospitals, and vertical programs), community members, private doctors and pharmacies—are highlighted and discussed. Ethnographic data presented in this article expose distinct gaps between national health policy rhetoric and the reality of access to health services at the community level in a highly marginalized municipality in one of Mexico’s poorest states. These insights have important implications for the structure and implementation of on-going reforms. [health care reform, access to care, insurance, trust, Seguro Popular]

Introduction

Mexico is a prime example of a country that has made significant strides toward improving the population’s general health and health care delivery. The government has contributed to this by investing in numerous government programs and health care reforms (Frenk 2006; Frenck et al. 2003; Frenck et al. 2009; Homedes and Ugalde 2006, 2009). Improving any health care system involves defining how the health care is delivered to all beneficiaries and then understanding how all patient populations seek care and experience the health system. Our original research in impoverished communities of Chiapas during implementation of the recent health care reform illustrates the challenges of bringing reform efforts to all communities, particularly those that are socially marginalized, indigenous, physically remote, and historically disadvantaged. Focusing on the stories of Chiapas’ campesinos (impoverished rural farmers), we present an analysis of the
health system, the implementation of the new government health care reform Seguro Popular (SP), and specific points of tension among the various stakeholders: the government health system (including public clinics, hospitals, and vertical programs), community members, private doctors and pharmacies.

In April 2012, the team that authored this health care reform announced in a *Lancet* publication that Mexico was approaching universal health coverage through enrollment of previously uninsured Mexicans in SP (Knaul et al. 2012). This enrollment, however, does not necessarily mean that all health care needs are being covered or that available coverage is effectively producing results. Our study provides one perspective on how the health care system can more fully engage with enrolled beneficiaries.

**Health Care Financing Reform: Seguro Popular**

Inadequate funding, a fragmented delivery system, and highly unequal power relations between patient and provider characterize some of the greatest challenges that have traditionally faced the Mexican medical system, especially in Chiapas. Since the first democratic change of power in 2000, after more than 70 years of single-party rule, the new government headed by the Partido de Acción Nacional (PAN) has sought to address one of the biggest issues affecting Mexican society—the fragmented public health system and deficiencies in insurance. The World Health Report in 2000 found that over half the Mexican population paid for the majority of health expenditures out of pocket (Lakin 2010; World Health Organization 2000), which often included catastrophic debt and impoverishing expenditures (Galárraga et al. 2010). The incoming minister of health, Julio Frenk, assembled a team to design a health reform that would address these economic concerns by providing universal coverage through an innovative funding scheme, Seguro Popular (or social health insurance). This would be available to all citizens, especially those not already covered through one of the other Mexican social security entitlements available only to citizens employed in the formal sector, such as IMSS (Instituto Mexicano del Seguro Social) or ISSSTE (Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado).

The program design has been described elsewhere (Frenk et al. 2006; Gakido et al. 2006; Knaul et al. 2006; Lozano et al. 2006); there has been much debate about the relative merits of its architecture and the philosophical assumptions upon which its structure is built (Laurell 2007). Nevertheless, even Dr. Frenk and his team recognized that SP had several challenges ahead. Above all, they stressed: “The absolute amount and the share of GDP spent on health from public sources must increase for the health system to respond effectively to the demands of the population, reach universal health insurance coverage, and expand the number of interventions to which affiliated families are entitled.”

SP has indeed increased funding for health care. Yet beyond budgets, SP’s designers realized the necessity of improvements in a number of patient-centered quality indicators: “client orientation and responsiveness of the health system, technical quality of care, availability of drugs, choice of health-care provider, availability of care during the evenings and weekends, and waiting times for ambulatory and emergency care, as well as for elective interventions” (Frenk 2006). Keeping these challenges in mind, we consider the experiences of the campesinos in the Sierra Madre region.

**The State of Chiapas, Mexico, and the Sierra Madre**
Chiapas is best known for the 1994 Zapatista uprising, when impoverished indigenous rebel groups of the highlands took up arms against the government to demand “democracy, liberty and justice” for all Mexicans (Ejército Zapatista de Liberación Nacional 2005). This was, however, only one historical moment in the state’s much longer history of complex cultural relations, conflict-ridden politics, and highly unequal economic realities. This article focuses, instead, on a less-publicized part of Chiapas—the Sierra Madre region in the southwest—home to the “Mexicanized Mam” people.

Unlike the indigenous communities in the highlands, the indigenous Mam communities were forced to abandon their traditional customs in the 1930s as political leaders sought to build a unified state in post-revolutionary Mexico (Hernández Castillo 2001). In modern-day Chiapas, the Sierra Madre region receives little attention because it is far from the Zapatista movement and fails to attract the attention of many foreign nongovernmental organizations (NGOs); unsurprisingly, its popular name is “la zona olvidada” (the forgotten zone). The campesinos in this area, specifically in the Siltepec municipality, live in poverty; corn and beans are their subsistence crops, and coffee their highly variable cash crop. The main measure of trade is the bulto, a sack of coffee that contains around 50–60 kilos of coffee beans. The average market value of a kilo of coffee is between $1 and $2 USD. Families will produce from as few as one—two bultos to over 20 bultos yearly, with the average being around 10 bultos. Although some families receive income through other important mechanisms such as small businesses, remittances from relatives working in the United States, or the government welfare program Oportunidades, the main economic measure for most is the bulto.

**Study Design: The Patient’s Pathway**

Exploratory ethnographic fieldwork was done June–August 2008 to gain a better understanding of where campesinos seek health care and what informs those decisions. The analysis reflects information gathered from 35 interviews in 13 communities within the Siltepec municipality. The communities were selected because they were affiliated with a project supported by the Boston-based NGO, Partners in Health (PIH). Study participants included 17 campesinos, 11 NGO-related health promoters, three clinic staff, two midwives/traditional birth attendants, a religious leader, and a SP administrative director. Molina conducted all the interviews. She is Chinese American and was a medical school student at the time of the study. She received no funding from PIH. Palazuelos is a binational Mexican American physician who holds a leadership position in the PIH Mexico team. Many of the insights and strategies written about in this article have been subsequently incorporated into PIH’s current efforts in Chiapas, Mexico.

Over a six-week period starting in July 2008, Molina approached a random sampling of campesinos who sought medical care at clinical training sessions for community health promoters and asked them to participate in the study after they had received medical attention. All approached agreed to participate, potentially because they were satisfied with having received care. As this was an explorative study in a rural area, all further study participants were recruited through key informant references and snowball sampling. Oral consent was obtained after hearing a thorough explanation of study goals and learning of the voluntary and anonymous nature of participation. Interviews followed a set of open-ended questions designed to elicit where people go when they are sick and why, particular experiences with the health system, and impressions of SP. All interviews were conducted in Spanish, recorded, transcribed, and translated by Molina alone.

Molina conducted content analysis on the data, generated themes, and consulted with
Palazuelos to ensure the interpretive validity of the aggregated and deidentified analysis. Palazuelos participated in the fieldwork portion of the study, largely through logistical support while conducting normal PIH-related activities; he did not perform any interviews and did not have access to the participant identifiable information during the analysis of the data. When Molina wrote a draft of her findings, Palazuelos helped edit the text.

Confidentiality and privacy were maintained throughout the study. No names, addresses, or other unique identifiers were recorded in the data. This study was approved by the Committee on Human Studies at Harvard Medical School and the Centro de Investigaciones y Estudios Superiores en Antropología Social (CIESAS) in Chiapas, Mexico.

**Health-seeking Behavior and Access to Care**

Health-seeking behavior is multifactorial: Social, political, religious, and economic factors contribute to how people identify and define illness, which then guides the decision-making behind how they seek care and agree to treatment. These factors form the demand side of health care delivery. The supply side of health care delivery, such as clinic accessibility and the availability of doctors or nurses and medications, reflects the standard health policy arena (Ensor and Cooper 2004; Wagstaff 2002). In a perfect world, each side would inform the other, creating an efficient health system that responds to the needs and wants of the population.

In Siltepec, seasonal factors impact health, illness, and health-seeking behavior. Income to support out-of-pocket health expenditures for private care and access to either public or private care reportedly played the biggest role in how campesinos seek care. Because families depend entirely on the annual coffee harvest, anticipating income and allocating money for health care expenditures becomes difficult. Absenteeism among clinic staff is higher in the rainy season, and cold weather brings a host of respiratory illnesses. Food supply varies by time of year, with a surplus after the harvest that must be rationed for the year. Scarcity is common before the next harvest can renew food stocks.

Transportation is cited as a major obstacle to accessing care, especially during the rainy season. When heavy rains begin, the land used for slash-and-burn agriculture begins to erode, and mudslides destroy the roads. Transportation to any health care facility becomes dangerous or impossible. With a touch of shame, one man said: “We are like little animals because we have to hoard medicine for the rainy season.” Another man reported:

> We are screwed in the winter [or rainy season]. The roads are impassable. Sometimes, food and groceries do not arrive. … It is very far from Siltepec, very remote, eight hours in travel. The roads and many rivers are blocked … the government does not care that we are stuck in the mountains, it does not want us to eat, it does not make the roads. We are suffering. There is no doctor, there is nothing. Everyone suffers. Here we are suffering … the government abandons us.

For the campesino, time constraints in rural life, the significant opportunity costs of seeking health care, and their previous experiences with both traditional and allopathic ways of seeing disease and healing shape the mentality that people need to find quick fixes for their illnesses. This discrepancy between community expectations of the clinic and the clinic’s overall limited scope lead many to private doctors and pharmacies.

*Private Doctors and Pharmacies*
The average impoverished individual living in a rural town in Siltepec has several local options for care. These include the local government clinic staffed by a nurse; a recently graduated medical student working for a mandatory social service year (pasante), or a contracted physician; traditional healers; and small home-based grocery stores. Distant options include private pharmacies, government clinics, and private physicians in faraway cities or countries. A study of Tzotzil-speaking Mayans in the Chiapas highlands found the most frequently visited option was the local grocery store pharmacy (67% overall; 54% reported it as the first option), and distant options were more likely to be used later in the illness course. As expected, lower socioeconomic status was associated with increased use of local options both as first options and exclusively, likely because of the relatively high cost of seeking distant treatment options (Granich et al. 1999).

Pharmacies are particularly popular spots for rapid diagnosis and treatment. Pharmacists have been granted the role of makeshift physicians, and many types of generic medications are available over the counter in Mexico. This care, however, is often of low quality: One study conducted in both Chiapas, Mexico, and Guatemala found that over 80% of medications recommended by drug vendors for mock clients complaining of symptoms suggestive of diarrhea or an acute respiratory infection were “unnecessary or dangerous” (Kroeger et al. 2001). In addition, the care is often highly influenced by profits made off the prescribed drugs, a glaring conflict of interest for the health care provider. Another study in Chiapas using patient interviews found up to 67% of all drug prescribers, including those who self-medicated, recommended treatment with nonessential drugs—particularly more brand-name and second-generation drugs—which led to higher costs. These patients also received poor advice, such as almost no information about oral rehydration solution for diarrhea (Flores et al. 2003).

In Siltepec, these trends were prominent. The reasons why patients seek fee-for-service care include a mixture of convenience, pride, and consumer choice. One health promoter explained that: “Many people go to private doctors because they arrive, pay, and that’s it. They go out of pride because they are seen and treated more quickly.” The long waiting lines, bureaucratic chaos, and rampant absenteeism found in some government clinics contrast unfavorably with the rapid, efficient visit to a private doctor who is readily available.

Providers at public clinics expressed the value of prevention and education in keeping communities healthy, but most patients valued curative care above prevention and education. Private doctors, in contrast, promise speedy attention and curative services, usually at elevated costs. Consequently, many campesinos are willing to spend a large portion of their income to receive this type of care. A consultation typically costs 200 pesos but can rise to as high as 4,000 pesos, which is a significant proportion of yearly income for many.

The view that health is achieved through medical care and that medical care is a commodity that is controlled by market forces sets the stage for how patients will understand quality: If the cost is high, the quality must also be high. Similarly, the financial ability to pay for services from a private doctor is a sign of social status because it shows that the person can afford that option. Because pills, intravenous fluids, and injections are widely perceived as effective, fast-acting treatments, some private doctors may take advantage of this belief and sell ineffective treatments at inflated prices. One woman with epilepsy revealed that she spent 2,000 pesos (approximately $200) on a four-month course of injectable B12 vitamin that she was told would cure her epilepsy. Some campesinos even reported having to sell their land, their only equity and financial legacy, to pay for ineffective treatments.
Guatemala: Traditional Healers and Fee-for-Service Hospitals

Communities in the Siltepec municipality are in close proximity to the Mexican–Guatemalan border. In neighboring Guatemalan cities, many fee-for-service hospitals cater to Mexican immigrants and native Guatemalans who can afford them. Multiple interviewees gave a variety of reasons why they have crossed the border to seek care. Some go for specific spiritual or traditional remedies thought to be more authentic in Guatemala. Others go because they feel they receive higher quality allopathic care. The trip represents a substantial investment in time, effort, and transportation costs, so people are incentivized to perceive great returns for their efforts.

Since local access to care is usually limited, many will tolerate their illness until they finally gather the courage and/or resources to “find their cure.” The idea that a single clinical encounter can cure an illness arises from years of infectious disease experience and the modern miracle of effective antibiotics. This paradigm becomes strained, however, as chronic diseases become increasingly problematic. One health promoter reported that four members of her community have tuberculosis; after years of trying to get care in the region, they finally all went to Guatemala to seek treatment. None of these people received follow-up care, which, for diseases like tuberculosis, presents a personal and public health dilemma.

Problems Expressed about Government Clinics and Seguro Popular

Government clinics were rarely described as a top choice for seeking medical care and are often considered only when private care is unaffordable. At the time of this study, the government clinics may have been affiliated with either the federal program, IMSS-Oportunidades, or Seguro Popular (SP). Campesinos described avoiding the government clinics because of operational problems, infrastructure deficiencies, and trust issues. This section will discuss these problems, which indicate larger challenges with the design and implementation of SP and various health services in the Siltepec municipality.

Differences in the Understanding of Health and Illness: Prejudice, Discrimination, and the Erosion of Trust

Shared beliefs about “hot” and “cold” illnesses and treatments exist in the communities represented in this study (Currier 1966; Foster 1994; Rubel et al. 1984). Doctors and nurses, however, rarely use such language to describe medical problems and medications. Although these health care providers may not know how to communicate with such language, they may also not understand that people will truly order their thoughts and symptoms within this framework. Those who hold traditional beliefs state that they have a hard time trusting those health professionals who belittle them for their “ignorance.” One religious leader provided a relevant anecdote:

It is very difficult … anything related to health because [the people] really believe that the medication is hot or is cold. One woman became despaired because she was unable to sleep at night because [the doctor] injected her [with a medicine] and she did not know if it was hot or cold, so she became worse. Others say “the doctors are no good, they’re useless.”
When asked how doctors respond to questions about whether an illness or treatment is hot or cold, one promoter replied: “These are other types of questions. The doctors don’t cure it. They don’t answer. They don’t know. They just ask for other medications that they know about.”

Gender roles and social dynamics in the community are other critical factors in health-seeking behavior and building trust. One health promoter admitted, “In this region people are a little private, they have a little shame, and many times they do not provide the exact information regarding their illnesses because of shame.” One midwife expanded on this theme and specifically identified the unequal power relationships between men and women as a source of mistrust between pregnant women and male doctors. One study on health-seeking behavior during pregnancy and childbirth among nonindigenous women in Chiapas found that preferences regarding childbirth depend on “the orientation of the caregiver toward birth and intervention in the birthing process, the location of childbirth, and the caregiver’s willingness to share power and authority with the woman.” This study found that only one out of nine women who had health insurance opted for an insurance-covered hospital delivery because “they valued being able to choose birthing locations and birthing positions and to have relatives present during the birth” (Hunt et al. 2002). Another study among poor indigenous and nonindigenous women found that many were hesitant to seek care from physicians during pregnancy because they perceived doctors as “expensive, distant or non-existent, untrustworthy, frightening, slow, and disrespectful,” while midwives were considered “more affordable, available, accessible, trustworthy, and mobile” (Tinoco-Ojanguren et al. 2008:1062).

Stigma and confusion surrounding congenital and mental health illnesses hinder people with those conditions from receiving care. One example highlights the discrimination against someone with cerebral palsy (CP), which one government nurse incorrectly labeled as mental illness. A child with CP was referred to the health center in Siltepec for an evaluation. When they arrived at the health center, the grandmother and child were chastised by a nurse: “We don’t deal with mental illness. Get out!” Recalling the incident, the grandmother recounted, “that was the first and last time. We are poor. We don’t have money to return. There’s no trust.”

Patient trust is fragile; one unpleasant experience can influence the health-seeking behaviors of a large proportion of a community as stories spread through social networks. Discriminatory attitudes and power dynamics continue to saturate the interactions between clinic personnel and patients. One midwife reported that the public doctor refused to see a young man whose face and body were swollen with a rash; he was refused treatment because he came after clinic hours (8:00 am to 2:00 pm). According to the midwife, the doctor dismissed the man: “No, go home. You see that schedule.” Such harsh paternalistic tones drive patients away, providing little incentive to return to the clinic for future health care.

One pasante talked about a woman with diarrhea who came to see him: “After taking the history, I decided to give Metronidazole. The woman asked if she could have Trimethoprim instead. Who is the doctor and who is the patient?” This rhetorical question revealed the doctor’s belief that he occupied a higher ground that commanded the patient’s respect and unquestioning obedience; instead of thinking that his job includes explaining his clinical reasoning to the patient, his statement implies that his reasoning should not be questioned.

This pasante then went on to criticize the people for not taking advantage of the many social programs that the government provides for the poor. He said: “Here everything is free. What is missing is the people’s desire or effort.” Another physician administrator referred to the campesinos in the municipality as “people of low culture,” a phrase tinged with condescension and classism. Similarly, a nurse at a health post rationalized the ongoing tension between the
community and the doctor by saying: “The doctor is very strict and the people are ill accustomed.” This implies that she believes patients must be obedient to the doctor.

According to several health workers, the rural health posts were designed for health education and promotion, not for medical attention. Yet many health workers do not meet the stated goal of health education. Little effort is made to discuss the cause of illness, how medications work, why it is important to continue taking medications even after symptoms disappear, and how to prevent a similar illness in the future. The consequences of failing to educate patients can be severe. One woman with epilepsy who we interviewed gave birth to three malformed newborns who died in infancy, most likely as a result of conceiving while still taking anti-epileptic drugs but without taking any preventative efforts that might mitigate her risk, such as folic acid.

Absenteism and an Inconsistent Supply Chain Damage Continuity of Care

Beyond the perceived quality of care, the most cited reason why campesinos do not go to public clinics is because the clinic staff rarely maintains a reliable schedule. One health promoter commented that the community clinic is closed three–four days a week and sometimes remains closed for months during the rainy season. A midwife noted that the clinic had been closed for two weeks and that the doctor is frequently absent. Such absenteeism is pervasive and possibly obstructs the flow of medications to a community because physicians must confirm diagnoses before medications for chronic illnesses, such as HIV, tuberculosis, diabetes, epilepsy, and hypertension, are distributed.

Several key informants reported that without such documentation, a nurse cannot dispense any medication, even if available, to those patients. Many health care providers interviewed talked about the difficulties of filling out paperwork to request medications and the frustrations with a weak supply chain. As an example, one man with epilepsy reported that nurses know of his condition and have filled out forms for his medications three times, but his treatment never arrives. The supply line even falters in the public hospitals, where inpatients might need to buy their own medications and medical supplies when the hospital’s inventory is empty.

Without the necessary medications, people continue with unmanaged chronic diseases. Even vertical programs for HIV/AIDS and tuberculosis that should provide free medications have fragmented medicine supply lines. One pasante described how he filled out the paperwork for two patients with HIV but had not received any medications for eight months since their diagnoses. One of those patients was pregnant and gave birth to a newborn who did not survive.

Inadequate Equipment and Complex Referral Systems Place Unrealistic Burdens on Poor Patients

Even though the study area had multiple clinics that were well built and designed to provide quality primary care, most were not equipped to diagnose, manage, and treat the wide variety of illnesses present in the communities. One religious leader asserted: “[In the clinics there is] nothing more than pure documents to fill out, fill out, fill out and then the job is complete without attention, without anything.” Similarly, most rural clinics do not have basic medical devices such as a glucometer, resulting in patients traveling three–four hours for a simple
glucose check. Other basic procedures, such as removing an intrauterine device or suturing a superficial wound, are not always performed in the clinics for lack of sterilized equipment.

In addition to a poor transportation infrastructure, the referral system poses other substantial financial and logistical barriers for the sick to navigate the public health system. In the Siltepec municipality, personnel in the community health posts (casas de salud) have the capacity to refer patients to the next level of care, which is the health center (centro de salud) in Siltepec. According to an administrative director, all patients must pass through Siltepec to get a referral to any higher level of care. From Siltepec, patients carry a paper pass to Motozintla, then from Motozintla to Huixtla, and then from Huixtla to Tapachula, if necessary. This referral system fails to take into account the financial consequences and delays in medical attention for those far removed from a referral center. One health promoter reported: “You can go dying, but if you do not pass through Siltepec and go directly to Huixtla, they won’t pay attention to you. This is how one could die. They will not attend to you because you don’t have a referral.”

Government ambulance services are unreliable or nonexistent and often charge passengers for gas. One woman related that she was told to bring 600 pesos for the ambulance ride between the nearest referral hospital and the city with the next higher level of care. Villagers therefore often pay a local owner of a truck to drive them to the health center in Siltepec, usually at inflated costs because of the cost of gasoline and the lack of competition among truck owners. Furthermore, the mountainous roads are in poor condition, especially during the rainy reason, increasing the travel time from four hours to eight hours in some areas.

Poor communication between different health care delivery systems in the Mexican system aggravates problems associated with the complex referral system. Even for vertical programs, like that for tuberculosis, private doctors, the Secretaría de Salud (SSA), and the IMSS systems do not readily share information about patients. This means that someone with tuberculosis who is diagnosed in an IMSS hospital in the nearest city may find it difficult or impossible to receive follow-up care with the SSA clinic in his or her own community. The situation is even worse for illnesses that are not covered by a vertical system, such as epilepsy, mental disorders, or chronic pain.

Real Costs for Patients Are Disregarded as They Navigate a Fractured System

Even with SP affiliation, there are a number of costs that are not factored into the package of services but yet pose barriers to care. One case is exemplary: A man with an enlarged lymph node visited a private doctor who made the diagnosis of biopsy-proven extra-pulmonary tuberculosis. This doctor correctly reported the case to the SSA, and the man received his medications each month from the SSA in a nearby community, but only after he traveled several hours and paid 300–400 pesos in transportation costs each time to pick them up. The clinic in his community was an IMSS clinic that could not receive the medications. Although the treatment was technically free, the structural barriers for accessing them constituted a very real cost.

This man, like many others with SP, was geographically limited to specific health care networks. One health promoter reported that SP did not function in a referral city, Motozintla, even though the SSA jurisdiction office was located there. When the man’s wife was sick, they went to Motozintla only to find out that her SP was not accepted at the hospital because it was affiliated with the IMSS system. The nearest SSA hospital was then over four hours away. This experience illustrates inevitable gaps in access to care when SP enrollment is not uniformly available across a fragmented delivery system. The individual is expected to navigate the gaps
independently, a difficult order for the most marginalized. This navigation is especially challenging for those who are often illiterate and do not have phones or access to the Internet.

A System that Demotivates Young Doctors

Most doctors in the rural health posts are pasantes, doctors who recently graduated from medical school and are doing their mandatory year of government service before entering residency or beginning general practice. As recent medical school graduates, pasantes have relatively little clinical acumen yet are assigned to a patient population that has been marginalized from the health care system and often have complex diseases. Unmanaged chronic illnesses, widespread infectious diseases, and traumatic events common in rural life are just some of the obstacles these novice clinicians face as they see their patients—clinical scenarios that would be challenging for even the most seasoned providers.

Pasantes are rarely given bedside-manner training or any formal mentorship. For example, one woman had a painful foot wound with an extruding muscle layer for two years. She went to the health center in Siltepec, where the pasante began to cut the extruding muscles without administering any anesthesia to the woman. She immediately passed out from the pain, leaving her family to worry that she may have actually died. From that point on, she, her family and most of her friends have chosen private doctors or Guatemalan healers because she has no trust in the public doctors. “They just give bad care,” she said.

One pasante described the disappointment he felt with his year of service, highlighting the difficulties of being placed in a rural clinic without adequate financial, logistical, or educational support from the SSA. Before arriving at the health post, the pasante, like many of his predecessors, had an idyllic vision of what his year of service would be like: He imagined himself as the village doctor who everyone would adore and trust. Instead, he recounted the deficiencies he saw with the SSA, especially in obtaining the medications and supplies needed for the clinic, despite having to fill out what seemed to be excessive paperwork.

The pasante was frustrated with his patients and blamed them for their form of thinking. He expressed disdain for their preference for quick remedies over health education and stressed how difficult it is to “change their mentality. … People come to the clinic through their own manner of thinking. They want a fast remedy and don’t realize that what I provide in the clinic is health promotion.” The doctor–patient relationship strains under this mismatch of expectations. In turn, communities often approach pasantes as transient government workers who need to be pressured to provide any care.

Weak Supply Chains, Perverted Incentives Created by Parallel Private Practices, and Unethical Behavior

Doctors who work in public clinics often hold their own private consultations. Despite entering the public clinic, patients will sometimes be referred to a private clinic for care and charged for medications from the doctor’s private pharmacy. With poor stocks of medicines in the government clinics, these parallel private clinics and pharmacies sometimes fill the need for necessary supplies. This system, however, also creates a conspicuous conflict of interest that may lead to the financial exploitation of the sick. For the entrepreneurial doctor, business improves if the government clinic functions poorly.
Even when people receive care in the clinic, some are charged wrongfully. One woman reported that she was charged 200 pesos for a Pap smear in the public hospital in a nearby referral city, even though she had a referral from the community clinic. One health promoter and one woman remarked that pregnant women must pay between 200 and 500 pesos ($15–$40 USD) to deliver in the public hospital, which has been reported in other studies (Hunt et al. 2002). The promoter also reported that his community has to gather the 300–400 pesos to pay a nurse to come and vaccinate the children, a task that the SSA ought to complete free of charge for community members. If patients complain, some allege that they are threatened that they will lose their Oportunidades, a conditional cash transfer welfare program where mothers in needy communities are given monthly stipends for complying with basic health and education criteria.

These are extreme examples of unethical actions by isolated providers, but the fact that patients have reported their occurrence has serious repercussions for the way government services are viewed. Government managers will certainly condemn such actions, but the incidence of these cases calls into question whether current regulatory efforts are adequate.

Lack of Information among the Patients about Available Programs

Many interviewees reported not understanding the purpose of SP. Some communities at the time of this study had nearly full enrollment in SP, while others had not even heard of the program. In communities with SP affiliation, substantial controversy surrounded its purpose and applicability. One pasante claimed that SP is an “extra” because it covers surgeries, and “everything else is covered by the SSA,” indicating confusion regarding the intersection of covered services through SP versus through the Ministry of Health. One midwife commented that SP covers only half the cost of the health service and half the cost of the medications. A nurse thought that SP is advantageous because “it finally covers everything,” but all SP documents clearly state that only certain cost-effective interventions would be covered.

Comments like these indicate the inconsistent experiences with, and therefore imperfect understanding of, SP coverage. This is likely because of a combination of limited coverage, lack of clarity about covered services, regular stock shortages, and the inconsistency with which different clinics adhere to SP guidelines. From the perspective of the individuals who are experiencing inadequate care, it is impossible to know which factor is at play—they only remember that the system failed them. In the words of one health promoter: “For what is SP? There is no good advantage. People do not believe in it. There is essentially no care.”

SP is slated to cover preventive services, but many people don’t receive those benefits. It becomes a vicious cycle as people perceive that the services are not available and then do not seek them out if they do become available. One man put it simply: “SP doesn’t work when you’re not sick,” even though one of SP’s main expressed goals was to also increase the utilization of cost-effective preventative care.

Inconsistent Rollout and Variable Implementation of Some Existing Programs

The ongoing implementation of SP demonstrates variable degrees of the program’s functionality. For example, certain groups of patients must overcome significant barriers to enrollment. At the time of data collection, only families with children born after December 1, 2006 were allowed to enroll, as part of another new government program called Nueva Generación. One health promoter described how only his family and one other were eligible for SP. Both families, however, were not able to fill out the paperwork because they did not have the proper
documentation for the newborn. Because many women still give birth at home, obtaining birth certificates for newborns is an obstacle that prevents them from enrolling in SP. To register the newborn, the mother must bring the newborn, the midwife or traditional birth attendant, and two witnesses of the birth to the civil registry, which can be eight hours away. One health promoter admitted:

[I]t is a little difficult because you have to go way out there, out to Honduras (a larger community), which costs money. From the moment that you leave your house, you are spending a lot. You have to make copies, you have to pay the midwife, and you have to pay for your food.

Study Limitations

A limitation of the study is the potentially restricted diversity of communities visited. These communities may have a heightened awareness and knowledge of the health system because health promoters in the community were undergoing training for accompaniment, health promotion, and basic triage of needs. Additionally, there was no systematic randomization of communities or participants to ensure a representative sample. Molina conducted, translated, and analyzed the interviews was not employed by PIH, but Palazuelos was employed by PIH at the time of the study. This could have generated bias in a variety of ways. There may have been a social desirability bias if participants gave answers that they thought the NGO wanted to hear; because the participants were sampled from patients receiving NGO provided care in the community instead of within government clinics, this may have inherently changed the patient population available for the study, potentially shifting the sample toward those discontent with government services.

Discussion and Conclusion

This article presents and analyzes the experiences of rural Mexican campesinos as they sought solutions to their health problems in a care delivery system undergoing internationally respected reforms. It is important to note that these perspectives were captured in 2008, in the early stages of the reform’s local implementation. This specific historical moment offers a unique opportunity to understand the reform from the vantage point of a poor population that was largely underserved in the preceding years and therefore stood to benefit the most from such health care system strengthening efforts. That the majority of the comments collected reflect a negative opinion of the reforms and of the system in general allows us to analyze what was missing and what could be done to improve future efforts. In short, these opinions demonstrate that by pursuing coverage before improving quality, health care reforms did not earn patients’ trust after years of poor performance.

The public health insurance SP was a central part of a larger Mexican health care system reform aimed at improving many supply side elements of health care delivery such as expanded access to a set of defined services and improved financing. In fact, the stated mission of the reform took policy rhetoric to new heights when it vowed to provide all Mexicans with the universal human right that only a government program was positioned to confer on citizens. Through scheduled evaluations, policymakers have measured reform outputs and found many laudable changes, such as a decrease in catastrophic costs (King et al. 2009). Most recently in 2012, the program touted nearly 100% coverage, to much international acclaim. However, the
publicity did not claim that this coverage was attaining maximum health results, or what has been called “universal effective coverage.” This gap in coverage and impact merits vigilant attention.

Care systems can only be as successful as they are utilized. Supply-side and demand-side barriers stand between patients and their access to and acceptance of services. Demand-side barriers “are defined as determinants of use of health care that are not dependent on service delivery or price … they include distance, education, opportunity cost, and cultural and social barriers” (Ensor and Cooper 2004). The architects of SP knew that since health care–seeking behavior is also exquisitely sensitive to perceived quality, a reasonable strategy to improve utilization would be to focus on the supply-side inputs necessary to improve quality over time. There are a number of other strategies available to reduce demand side barriers, such as providing culturally appropriate education campaigns, transport loan funds, incentives to reduce the cost of lost working time, and improved transparency about accreditation systems (Ensor and Cooper 2004). Even though it is not known which of these strategies are most effective, Mexico’s health care reforms focused less on these interventions than on previously mentioned supply-side measures.

In a post–Alma Ata Mexico, there is an unfortunate disconnect between how preventative and curative care are valued by health systems and patients. For one, patients almost universally sought curative care, which rural clinics were poorly positioned to provide due factors such as inadequate human resources and inconsistent medicine supply chains. These realities limited potential clinical opportunities to teach patients about the power of prevention. Instead, campesinos described clinical encounters dominated by a fraught doctor–patient relationship that was laden with paternalism and a steep power gradient instead of mutual understanding and educational opportunities. Equally as frustrated, providers almost always put the onus of overcoming logistical challenges on the patient, blaming them when the challenges were insurmountable. Although some of these challenges were based on the local climate and poor infrastructure, many others, such as the broken referral structure across a fractured network of providers, were created by the system itself. Fixing these issues seemed outside the reform’s efforts, even though they were pivotal to whether the sick could navigate the system and even begin to judge the quality of care received.

The strategy of pursuing enrollment first and quality improvement second is precisely what the campesinos in this study rejected. For them, SP in 2008 felt like another empty government promise; although they held an enrollment card and were told they could access an expanded array of services, in reality their local health care system delivered a much more limited range of services with highly inconsistent quality and persistent inconveniences that signaled business as usual. In fact, we observed a “trust chasm” that partially accounts for the all too common yet widely lamented “failure of publicly financed health care to reach the poor” (Wagstaff 2002:102).

Trust is created through the provision of patient-centered responsive care that, where necessary, focuses on a curative outcome (Olsen 2010). Without improved quality and trust, many beneficiaries often circumnavigate government services in favor of private care. Although private care is expensive, unregulated, and variably of poor quality, the providers are nonetheless perceived as kinder and more responsive and seem to offer a more tangible “solution.” A meta-analysis by Basu et al. (2012) analyzing peer-reviewed studies and reports found that:

[Pro]viders in the private sector more frequently violated medical standards of practice and had poorer patient outcomes, but had greater reported timeliness and
hospitality to patients. In addition, reported efficiency tended to be lower in the private sector … resulting in part from perverse incentives for unnecessary testing and treatment. [Basu 2012:1]

Facing multiple uncertain variables and high opportunity costs to access care, the average campesino is drawn to the packaging that private care has to offer. Some campesinos have been conditioned to believe that the only quality, reliable care is expensive care. In fact, this search for quality care often takes local people across borders to private doctors and traditional healers in Guatemala. This reflects a phenomenon common to richer populations in the North but not commonly described in the rural poor: medical tourism (Hopkins 2010). The stories presented in this study demonstrate how a campesino’s commitment to seek a responsive service provider can still lead them to poor quality, often predatory, care.

To cross the “trust chasm” described by the campesinos in this study, it will be imperative to truly improve the range and quality of care by addressing both the demand- and supply-side barriers to care. The problems campesinos described with the doctor–patient relationship—such as perceived discrimination, paternalism, mistrust, prejudiced attitudes toward mental illness, and poor guidance for pasantes working in rural areas—all call for solutions in the spheres of clinical education and professional mentorship. Skills such as building a horizontal doctor–patient relationship, sharing decision-making capacity, and expressing empathy can be taught and modeled for medical students and young trainees; perhaps the most powerful reform will be to put the “caring” back into health care (Onie et al. 2012). To do this, health services designed for a population must still be centered on servicing each individual patient. Ministries of Health must also regulate abuses by both public and private providers who neglect, endanger, or take advantage of patients. This process will not be easy, however, as it would entail investigating abuses and enforcing penalties against powerful local interests.

NGOs are another important health actor that can help find solutions. Forming what has been sometimes called “a parallel system,” many NGOs resist forging a relationship with government agencies, as they desire independence from faulty systems. One issue common to all NGOs, however, is financial sustainability. NGOs may be able to form more sustainable programs for change by collaborating with government counterparts. The significant challenges presented in this study should, in turn, be seen as important opportunities. NGOs could help improve the quality of care and trust in a number of ways: assisting in the training and mentoring of young social service doctors so that their social service year is not seen as a burden but as a year of growth and awareness; advocating for the sick as they navigate well-known barriers such as imperfect supply chains and information disparities; conducting quality improvement research; and evaluating demand-side barrier interventions that may have been otherwise overlooked in the greater policy arena. Strategies that improve services in specific settings could then be scaled up to the larger system in a step-wise fashion that improves the likelihood of their success.

Mexico’s health care reform has presented innovative solutions to vexing age-old delivery questions but also highlights persistent difficulties with implementation in the poorest settings. With strategic modifications, including multidisciplinary collaborations focused on achieving common goals and cultivating patient trust, future reforms may be able to more fully and more quickly achieve needed changes in marginalized areas like the communities scattered throughout the Sierra Madre Mountains of Chiapas.

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ANNEX

Figure 1: Map of the Municipality of Siltepec circled on a map of Chiapas, Mexico (accessed: http://www.care2.com/c2c/groups/disc.html?gpp=3109&pst=87923) and a GoogleEarth image showing each community visited, represented by a pushpin, and their proximity to the municipal capital of Siltepec.
Figure 2: Pictures of dangerous road conditions during the rainy season. These are the only roads that connect these communities with the referral center, Siltepec.
Figure 3: Pictures of government clinics that were closed during normal business hours for extended periods of time.