Material and political dimensions analysis of the legal exclusion in the social protection in health

Extensive abstract

Throughout the last century, Mexico has experienced a series of political, economic and social transformations which might suppose an improvement in the general well-being of the population. Nevertheless, the persistence and deepening of the economic inequality among the Mexicans, has determined the persistence and even the growth of the sanitary inequity that has characterized the country in the 20th century (Bronfman y López, 1999).

It is necessary to remember that in Mexico, and in agreement with the established in the General Law of Health, the social protection must allow the State to guarantee to the whole population the access to the medical-surgical, pharmaceutical and hospital services, to cover the needs of health by promotion interventions, prevention, diagnosis, treatment and rehabilitation, made in an effective and opportune way and with quality, without disbursement in the moment of the utilization and without discrimination. In spite of the law stipulations, from middle of the 20th century, though not in an exclusive way, Mexico has invested in the economically active population health by designing health services for attending the formal workers and their families.

This policy did not bear in mind the demographic changes. It is why the government did not anticipate the demands of attention that would result from the demographic transition, product of the life expectancy increase, from the infant mortality decrease and from the mother mortality and in consequence of the general mortality, as well as from the improvement of the nutrition and from the fecundity decrease.

Also, it is necessary to add the lack of financial protection. This represents the situation of the homes which lack access to a health assurance, public or private, in which more than the half of the Mexican population lives and which redounds in a low health system performance. This lack of protection is translated in excessive expenses in health (catastrophic and impoverisher), in a minor access to the services by a part of the population, in low quality of the health services and in the inefficiency in the use of the resources in the health sector.

Thus, the own reality has clarified that the evolution of the excessive expenses throughout the time, constitutes an important evidence about the health system performance, as the financial protection is sensitive to the general economy performance. That is why, in periods of crisis like the happened ones in Mexico in the last decades, in which an important part of people lost employments, it involved also the loss of access to the social safety and therefore to the financial protection in health for the workers of the labour market formal sector. In this kind of contexts, it is probable to observe an increase of the number of families living more near the poverty line and with fewer opportunities to work. All this factors reduce the families' capacity to be able to support pocket expenses in health.

It is necessary to highlight that inside this context, the field of the health does not stop being an extremely complex reality, as it assembles biological, economic and sociocultural diverse elements. It represents the space of policies conjugation (in macro and micro levels), beliefs, traditions, taboos and family practices.

So, the health turns out to be the reflex of a wide range of situations where it combines social inequalities, economic lacks, cultural variants, use of the geographical space and available resources (both natural and material kind) for the health. In other words, the process of health-disease is a dimension of the general inequality, where it conjugates the effects of other dimensions that can be recognised in the distribution of income, in the participation forms in the production, in the life conditions, in the differential access to the opportunities of individual progress, among others.

This situations set has done that numerous authors coincide in emphasizing the lack or deterioration of social links as a consequence of the unemployment or the precarious employment caused by the economic growth models in summit (Tezanos, 1999; Waiter, 1998).

The changes on the production processes in the current markets, the extensive predominance of political neoliberal positions that promote the deregulation and the social vulnerability, and a worrying trend of social break are, among others, some of the circumstances mentioned by the theorist at the moment of making clear that the problematic of exclusion is not anything concrete and accidental that goes beyond the poverty and the social inequality, but it turns into the manifestation of the current change processes that lead a new society of dualisms and social stratification (Tezanos, 1999).

As Sami Naïr (1999) indicates, nowadays there is a deeper social revolution than all the political revolutions experienced on the modernity: a revolution that affects the social identity, the social link itself. In effect, if a new definition of the social link is being constructed, it is because its two parameters, the work relationship with the citizenship (and probably it would be necessary to add the family), they have changed. The changes in the work orbit have generated that the precariousness, the mobility and the vulnerability are the "new" characteristics that all the specialists coincide in using to describe its basic features.

From these considerations, this paper approaches to some worries that are related to wonder about which are the forms and guidelines that the access to the health services assumes?, which is the effect of the socio-economic factors in the access to these services?, which is the effect of the political-legal factors in the access to the health services?, and definitively which are the forms that assume the processes of legal exclusion to the health social protection?

To develop a discussion guided by these questions implies be conscious about the individuals demographic factors and their homes and the socioeconomic situation in which they are, but also territorial or geographical, political and legal aspects, among others, which intervene, influence and determine the characteristics of the exclusion-incorporation process.

The analysis is carried out from the utilization of secondary information sources which allow to calculate the pertinent and sufficient indicators for the proposed analysis, as well as to design the model of analysis which allows identifying the guidelines of legal exclusion to that a great part of the Mexican population is exposed.

Hereby, the model of analysis allows understanding the way in which the deep and extreme social inequalities drive to the exclusion when they generate competition structures and conditions in which wide sectors of the population, because its formation or due to the place in which they live, among others, cannot take part of the general processes.

In a general way, the study shows that the population's health exclusion conditions have two fundamental dimensions. On the one hand, the excluded population faces multiple sources of exclusion in all analysis levels. On the other hand, the degree of exclusion of this people is almost total. It means that when one of the factors is presented with high levels, the effect of other variables also is important. This information indicates that thinking the problem about terms of policies actions, these should be multisectorial, intersectorial and integrals and not to concentrate in just one dimension or factor of exclusion.

Another data that is important to stand out is that both, the health exclusion and its determinant conditions, have big variations at the interior of the reference groups. Inside the strategies set for reducing the health exclusion there exist those which are focused and specifically orientated to extend the social protection of health in those groups or more affected zones.

The analyzed information indicates that the poverty turns out to be determinant for the health exclusion and it is recognised as one of the most important determining factors. In this respect and since it has been said in diverse instances and existing documents, the health exclusion allows the existence of poverty, then, the fight strategies against the poverty are very tied to the combat against the health exclusion, though it is true, that the condition of poverty does not determine the exclusion not vice versa.

Finally, it is important to emphasize that not having a health assurance turns out to be an important access barrier to the attention very tied to the labour condition, situation that raises the need to check the structure of the existing social safety regime, but also it becomes of vital importance to analyze the impact of the development health programs health as the Popular Assurance (*Seguro Popular*), on the population with legal or labour coverage.

It is necessary to highlight that the document presents some limitations that have a narrow relation with the type of information used as input. Thus, the used indicators do not catch a significant differentiation in the degrees of health exclusion according to the genre and the phenomenon of the exclusion seems to affect in an indiscriminate way men and women in the level of the analysis presented here, which suggests the need to go deeply into more specific and binding indicators between genre and health exclusion.

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