Primary Health Care under Mexican Social Security

The Experience of the IMSS-COPLAMAR Programme

International Labour Office Geneva

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for Social Security Studies
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International Labour Office Geneva

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INTRODUCTION

Through its IMSS-COPLAMAR programme, the Mexican Social Insurance Institute "has achieved a model of integral health care with the participation of the community. As a general principle, the aim is that in each locality there should be a health diagnosis which will help to identify problems and to formulate a health plan which is revised annually".

Ricardo García Sáinz
Director-General
Mexican Social Insurance Institute

CHAPTER I

THE EXTENSION OF SOCIAL SECURITY TO MARGINAL RURAL GROUPS

The 1943 Social Insurance Law

The earliest formal legal measures concerning Mexican social security date back to 1917, when the Constituent Congress, which adopted our Charter, declared in article 123 that: "It is considered socially useful to establish people's insurance funds, for invalidity, for life insurance, for involuntary cessation of work, accidents and others with similar aims; therefore the federal and state governments should encourage the organisation of institutions of this nature to introduce and develop protection for the people."

These constitutional provisions, on the occasion of the 1929 reform, led to the decision to enact the Social Insurance Law covering insurance against invalidity, death, involuntary cessation of work, sickness and accidents and other similar risks.

The first law, which was published on 19 January 1943, recognised and gave expression to these aspirations incorporating them in an effective instrument of social policy which made possible the practical nation-wide application of a structured system, supported financially by three parties: the employers, the workers and the Federal Government. The system came into being as a public service and a compulsory insurance operated by a decentralised institution with full control over its own assets.

As stated in its preamble, the 1943 Law was limited in its scope to wage earners in the private sector and other groups of dependant workers whose activities and occupation meant that they could be assimilated to the foregoing for insurance purposes. This was in line with the classical theory held at that time, that "the social insurance scheme cannot be applied in a general or indeterminate way to all individuals within society, but only to that sector of the population consisting of persons working for a wage or salary". Another paragraph stated that "this compulsion to insure will henceforth apply only to workers employed in private undertakings, state establishments, or those under workers' or joint administration; to the members of producers' co-operatives and to special apprentices working under contract".

For administrative reasons and due to the lack of medical care institutions, the compulsory social insurance was introduced gradually step by step, taking into consideration the industrial development, geographical situation, density of insurable population and the practical possibility of setting up the necessary services.

The first area selected was the Federal District, where application of the Law began on 1 January 1944.

The original Law covered protection against the following risks:

- employment accidents;
- occupational diseases;
- non-occupational diseases;
- maternity;
- invalidity;
- old age;

- retirement due to age; and
- death.

The coverage was grouped under four insurance branches:

- employment accidents and occupational diseases;
- non-occupational diseases and maternity;
- invalidity, old age and death; and
- involuntary retirement in old age.

Statutory provisions subsequent to the 1943 Social Insurance Law

As foreseen in article 60 of the 1943 Law, the Official Gazette published on 27 August 1954 the first "regulation specifying the manner of application of the social insurance scheme to rural workers in the states of Lower California, Sonora and Sinaloa".

The experiment was carried out in the 13 communal districts having the largest agricultural area, the greatest variety of crops and the most highly developed technical processes, which also had controlled irrigation and water supply or deep wells, credit from state and private banks, grants for the cultivation of certain crops, the purchase of crop futures and a sufficient road network.

The compulsory social insurance for rural workers covered all those engaged in true and proper habitual rural work in any agricultural, stock-rearing, forestry or mixed undertaking, whether they were labourers in tied housing, temporary workers, casual workers for specific tasks or members of the local agricultural or ejidal credit societies.

The following were considered as rural employers: proprietors, owners, ejidatarios, settlers, tenants and share-croppers who employ workers.

The contributions for employers and workers were fixed by the Government for each communal district concerned.

This regulation laid down the method by which account was taken of the number of hectares under production and the type and conditions of cultivation in each case, in order to fix the employer and worker contributions.

The bipartite contribution scheme for general sickness, maternity, old age, retirement and death was made applicable to the members of agricultural and ejidal credit societies, as a clear token of the Federal Government's support.

Subsequently, in the 1959 reforms, article 60 was extended to include the possibility of fixing the dates and methods of introduction of the compulsory social insurance for rural wage earners in the districts in which this insurance was already in effect for urban wage earners. For each of these there was a separate financial scheme within the framework of the general insurance scheme.

The benefits provided were both in kind and in cash.

The benefits in kind consisted of:

(a) medical, surgical and pharmaceutical care for up to 26 weeks;

(b) hospitalisation services;

(c) prosthetic and orthopaedic appliances, in cases of employment accident or occupational disease;

(d) obstetric care; and

(e) assistance for nursing mothers.

The cash benefits consisted of:

(a) allowances for temporary incapacity and maternity;

(b) assistance with funeral expenses and for nursing mothers; and

(c) pensions, allowances and termination payments.

Article 60 of the 1943 Law empowered the Federal Government, after a study and report by the Mexican Social Insurance Institute, to determine the dates on and methods by which the compulsory social insurance should be introduced for wage-earning rural workers, in the geographical districts in which it was already operating for the wage-earning urban workers.

The intention of the Law regarding membership in rural areas was very clear. It left open the possibility that at the right time there should be new programmes for extending membership to meet specific situations at given points in time; by this means it would be possible to extend the scope of application of social security in Mexico.

Article 80 laid down that the offical bank was required to provide credits, apart from those for preparatory maintenance work, in the amounts needed to pay the social insurance contributions, where the scheme for rural workers had been or was being extended; and it stated more clearly what should be in the decrees to be issued by the Federal Government in relation to the Mexican Social Insurance Institute. At the same time, the latter was to base its recommendations on its statistical, financial and economic experience. In sum, it set out the appropriate legal conditions for continuing to promote the extension of the social insurance scheme by including rural workers, ejidatarios, those holding land in common and small-scale proprietors.

In the corresponding decrees, it was stipulated that account must be taken of the social needs and the particular economic characteristics of these insured persons, the bases on which the premiums and cash benefits should be assessed and the special conditions under which other types of benefits could be awarded.

Articles 60 and 80 as amended on 30 November 1959 took account of the experience of the 1954 plan and provided the basis for the "regulations for the compulsory social insurance of rural workers" which were published on 18 August 1960 in replacement of those dated 27 August 1954.

These new regulations cover:

(i) wage-earning rural workers;

(ii) seasonal rural workers; and

(iii) the members of local ejidal credit societies.

To the first of these categories was applied the scheme for urban wage earners, based on the classical worker-wage contributions benefits pattern, using the machinery of employers' advices, covering all the branches of insurance and all the benefits.

For rural seasonal workers these new regulations took into acount the features of their work, making specific provisions to provide them and their entitled families with medical, pharmaceutical and hospital services as well as cash benefits for employment accidents and other particular risks.

Due to the nature of seasonal work, it was specified that the State would contribute to the cost of the services provided to these workers and their families by means of a reasonable sharing of the contribution between the State and the employers. The rural employers in all the areas where the provisions of the Social Insurance Law and its regulations were applied, as well as those to which the social security scheme was being extended, were to be freed from the obligations imposed on them by subsection II of article 197 of the Federal Labour Law, by transferring their responsibility to the Mexican Social Insurance Institute.

The contributions are payable only by the rural employer, without any deduction from the seasonal workers' pay. Half the total contribution is paid by the State and the amount is fixed per worker-day. The system of "coefficients" per unit of surface area and per type of cultivation is maintained. The medical services are provided on presentation of the "sickness advice" which the rural employer gives to his seasonal workers when they need it for themselves or the entitled members of their families.

Ejidatarios and small farm owners continue to operate under the bipartite contributions system, while retaining the right to all the benefits provided for in the Law.

On 14 June 1961 the Official Gazette published the Decree of 7 June 1961 incorporating in the social insurance scheme those ejidatarios and small-scale farmers who did not belong to local ejidal or agricultural credit societies, in the municipal areas of Mexicali, Tecate, Tijuana and Ensenada in Lower California, and in the areas of San Luis Río Colorado in the State of Sonora.

As up to that date ejidatarios and small farm proprietors who did not belong to ejidal or agricultural credit societies had been excluded from social insurance, the Decree aimed at remedying this gap. It was also stipulated that the insurance scheme would be adjusted in line with the provisions of the Social Insurance Law and its regulations. At the same time, under the provisions of this Decree, both insured persons and their entitled family members listed in article 54 of the Social Insurance Law then in force obtained the right to all the benefits provided for in that Law for all branches of social security, subject to the terms and conditions applying.

For the branches covering non-occupational illness, maternity, invalidity, old age, retirement and death, the insured persons remained under the tripartite contributions system.

The Law of 7 December 1963, which brought cane sugar producers and their workers under the social insurance scheme, was necessary because of the particular contractual relationships between sugar producers and cane producers, not only because of the existence and legal definition of areas of supply for the mills - linked with the credit policy which guarantees permanent activity in cane sugar production - but also because of the method of supplying and obtaining sugar-cane and the established system of annual disposal of profits, based on the output of the mills.

The social insurance schemes work on the basis of calculation of probabilities, the theory of risk and a restricted concept of solidarity in relation to these, as they only cover employers in relation to their workers when there is an employment contract within the traditional legal framework. Social security, on the other hand, implies the adoption of new obligations and rights which express a wider social solidarity in the face of risks which are common to the whole of a community. It is because of this new concept that this law establishes solidarity between industrial sugar producers, cane producers and the workers employed by them, whether they be permanent or seasonal wage earners; and it also specifies what is required of the employers for financing the social insurance for the benefit of sugar-cane producers and their workers.

There is no doubt that the national sugar industry cannot develop healthily if the economic and social conditions of those who supply it with its raw material are unsatisfactory. The sugar industry firms are indissolubly linked with the living conditions of the cane producers. Further, there is such a close economic relationship that the existence and development of the industry depend entirely on the work of the cane producers. This economic solidarity leads to a social solidarity from which one derives the rights and obligations set out in this law, which aims to ensure that the sugar producers play their fair part in the inclusion in the compulsory social insurance scheme of the rural population that provides them with the raw material for their industry.

The December 1970 amendments to the Social Insurance Law extended the benefits of the insurance for the rural population still further. This reform took into account the special economic and social characteristics of those newly subject to insurance. There was no doubt that the traditional structure of the social security scheme needed changing in order to be applied effectively in rural areas and to enable it to protect the largest possible number of people in a short space of time.

It is thus evident that whilst the machinery set up before this reform was more or less adequate to meet the demands of the urban population, this was not so for the special needs of the peasantry. Adaptation of the social security scheme to the rural milieu had to be carried out on the basis of the institution's own experience and with the support of new programmes which could involve other governmental institutions so as to achieve better co-ordination and maximum economy of resources in their joint efforts.

Given the urgency of taking measures which could solve the whole range of problems arising from the extension of social security to rural areas, gradually and in line with the particular needs of each region, it was considered socially more desirable to apply immediately new methods or methods which could be improved and refined in the light of experience.

We have mentioned above the fact that the December 1970 reform of the Social Insurance Law had made it possible to take into account the special economic and social conditions of those newly coming under social insurance.

However, the reform goes far beyond meeting the particular needs of the newly insured, as in fact it involves a basic change in the very notion of social security, giving it a different and higher profile, which has helped greatly in further extending and better applying it in rural areas, as well as improving its operations for insured persons in the urban centres.

As to the risks covered, one can observe that the various arrangements set out in the different decrees relate to the degrees of need; there is however no great variation, as from the outset the insurance covered all the

major risks that can affect insured persons and that are normally covered in a general social insurance scheme. Particular additional features have also been established for certain areas and, in some cases, depending on the risks occurring: this is particularly noteworthy in some sectors of industry, at some workplaces and in the case of occupational diseases.

On 25 February 1972 the Official Gazette published the Decree extending social insurance to ejidatarios members of ejidal credit societies, of joint associations or credit unions involved in growing sisal in 58 municipal districts of the State of Yucatán. This Decree was important as it marked the first time that use was made of the statistical, administrative and financial experience of the Mexican Social Insurance Institute and that these groups were able to join the compulsory scheme with special arrangements affecting the nature of their benefits. The statutory instrument itself defined the financial scheme, based on the contributory capacity of rural families, and set out standards and procedures appropriate to the special conditions applying.

In putting into effect the sisal Programme the Federal Government applied the December 1970 reforms, which clearly stated the need to take into account the special economic and social circumstances of the newly insured persons.

In applying the compulsory social insurance to the sisal producing area, the ejidatarios belonging to credit societies were provided with insurance covering non-occupational illnesses, maternity, old age and death. The nature of the benefits was specified, along with the financial obligations under a bipartite system, necessary in order to meet the insurance expenditures. The obligations laid on employers under the Social Insurance Law and its implementing regulations were assigned to the credit society, joint group or credit union to which the insured persons belonged.

The incorporation of this group laid the basis making possible a more thorough-going and rapid inclusion of new groups of ejidatarios, persons working land in common and small proprietors, with a financial organisation enabling them to participate in a system of rights and obligations based on the modified scheme.

The 1973 Social Insurance Law

The Social Insurance Law of 26 February 1973, published in the Official Gazette on 12 March marked the most important stage in the process of gradual extension of social insurance to rural areas. In fact, this new instrument represents the key element in the entire legislative provisions governing social security in Mexico. This is because the provisions that were previously scattered through decrees, regulations and other legal instruments were now confirmed and brought together in the single text of the Social Insurance Law.

In relation to the Mexican Social Insurance Institute, article 16 of this Law stipulates that the Federal Government will lay down by decrees the arrangements for the compulsory scheme which are needed to provide the benefits of social insurance to wage-earning rural workers as rapidly as possible, taking into account their needs and capacities, the social and economic conditions of the country and the special circumstances in each different region.

Another particularly good point contained in the 1973 Law in relation to rural social security is the provision in article 23 stating that the obligation to register as members of the scheme and the other operations

affecting those subject to insurance under the compulsory scheme covered by the Agricultural Credit Law shall be the responsibility of the ejidal and rural credit institutions and the regional banks to which the Law refers, and of the National Ejidal Development Fund and other organisations of a similar character and with the same objectives.

Up to now we have looked at some of the main aspects of the provisions in the 1973 Law relating to extension to the agricultural sector. One can now move on to consider some of the social effects. In establishing the system of social solidarity, the new Law made it possible for the redistributive effects of the benefits provided by the Institute coupled with the application of organised social solidarity to benefit the population groups most deeply marginalised economically and socially.

The Federal Government can, on the basis of the new Law, define the areas of severe marginalisation and establish for such areas the scheme for providing social solidarity without direct costs for those concerned. This system is combined with medical services for the basic benefits, remedial treatment and social and educational activities that can assist in regional development; and payment for social security can be made in the form of days of work.

So two major schemes are operating in the rural areas, referred to respectively as the modified scheme and the social solidarity scheme.

Although there is now an adequate legal framework for the extension of social security to those most disadvantaged, there nevertheless remain practical and technical problems in implementing the theoretical provisions and in meeting the widespread public desires.

The firm decision of the national authorities to extend social security led people to look for a new approach, that of providing appropriate social security in the light of the social and economic characteristics of rural families, solving the problems of limitation as compared with the ordinary urban scheme and establishing what has been called the modified rural scheme.

Its basic differences compared with the ordinary urban scheme lie in the nature of the benefits and the character of the financial obligations.

The financial scheme set up has been designed to minimise the deficit, by providing the opportunity of bringing in all the ejidal or communal groups, whatever their credit organisation, permitting them to take on commitments.

There is no difference in the members of the family who are entitled: they consist of the insured person, his wife or common-law wife, children aged under 16 or under 25 if still studying in national educational establishments or if they cannot support themselves by their own work because of a chronic illness, physical or mental defect, up to the time when their incapacity ceases. Entitlement also extends to the parents of an insured person if they are financially dependant on and live with him.

In the sickness-maternity branch, they are entitled to all the benefits in kind.

The difference is that they do not have the right to the cash benefits under that insurance. The only cash benefit that it provides is the funeral grant on death of the head of the family or insured person, as provided by law.

The short-term cash benefits are excluded, not solely because of their cost, but since in many rural areas the level of these allowances is higher

than the regular income of ejidatarios and those working in common; according to studies by the Mexican Social Insurance Institute, this would lead to an abuse in the demand for medical services and thus raise the operating costs.

The modified scheme allowed for the incorporation of those in the rural sector who have the lowest contributory capacity. Nevertheless, it left on the margin of society the great mass of Mexicans who are deeply marginalised economically and socially, though partially protected by the national health care assistance scheme.

The possibilities of an approach covering these groups appeared to be three-fold:

- to wait for their economic development;
- to increase the resources of the national health care scheme; and/or
- to extend the redistributive effects of social security.

The policy adopted by the Government of José López Portillo was to extend the redistributive effect of social security by setting up social solidarity services.

To carry out this policy, it was necessary to eliminate various limitations in order to provide social insurance benefits to different population strata, without imposing on them at a particular time financial burdens that they could not support.

It was therefore advisable to build up solid bases making it possible to carry out this decision without upsetting the financial equilibrium of the Mexican Social Insurance Institute, to the detriment of its primary objectives. Consequently, the Federal Government assumed a major part of the financial burden both for the capital investment and the operating costs. In its turn, the Institute assigned substantial sums, but maintained its financial balance and provided a fairer basis as between insured persons for the system of financing, in that the higher income social groups contribute the major part of the cost of social security and social solidarity.

The social solidarity programme pursues the following objectives:

- to provide medical, pharmaceutical and hospital care solely for those population groups which, because of the stage of development of the country, are profoundly marginalised in the rural, suburban and urban areas and have been determined by the Federal Government as qualifying for the benefits of social solidarity;

- to create for this purpose a national network reinforcing the Mexican health care infrastructure, making available material, human and financial resources to provide effective and timely services of general medicine, gynaecology and obstetrics, paediatrics, surgery, internal medicine, dental care as well as the main auxiliary services of diagnosis and treatment, laboratories, X-rays and pharmacy; and

- to base the social solidarity services on the experience of the Mexican Social Insurance Institute, seeking the highest productivity of operating resources and thus the lowest cost and proper co-ordination and complementarity with the various bodies that play their part in achieving and maintaining health, security and social solidarity.

The obligations for those benefitting from social solidarity are limited to providing ten days' work per year on tasks benefiting their own communities.

The community work ensures achievement of the final purpose of the social solidarity services, namely that those who benefit from it should have the means and the services that enable them to raise their standard of living and thus reach the stage where they can be protected by a more complete scheme.

The social solidarity services call on the solidarity of those who are insured to support the marginal sectors; they provide the latter with a real prospect of receiving the benefits of the system and they open the way to a social security scheme which can aim to operate as a redistributor of wealth, stimulating real and progressive growth which will enable people to attain full productivity and eliminate material and cultural limitations.

The Government of José López Portillo considered that the Mexican Social Insurance Institute, if it received contributions in line with the economic situation of the country and such as to stabilise its financial situation, would be in a position to obtain surplus resources to benefit social solidarity.

Agreement setting up the General Co-ordination Unit for the National Plan for Depressed Areas and Marginal Groups

At the beginning of 1977, the Mexican Government reorganised its priorities in order to redirect its development model. As part of this, the Government decided to carry out a policy aimed at reducing the marginalisation of almost 30 per cent of the population.

For this purpose, among other measures, the General Co-ordination Unit for the National Plan for Depressed Areas and Marginal Groups (COPLAMAR) was set up, with the aim of considering and proposing effective measures to meet the needs in the depressed areas and among marginal groups to suggest methods of co-ordination of the activities of the public bodies and institutions, as well as between the programmes aimed at this type of area and these groups of people.

As well as analysing the problem, the Government set out a workplan covering the economic, political and social situation of this type of community within the broad framework of short, medium and long-term planning. This included adoption of the administrative measures needed to carry out a series of actions designed to provide the marginal rural areas with the material and organisational basis needed for them to participate in a fairer way in the national wealth.

For this COPLAMAR built its basic structure on the following functions:

- taking proper advantage of the productive potential of the marginal groups in the areas where they live;
- promotion and diversification of work opportunities by channelling public and private resources and training the population groups concerned;
- making better use of the resources in the marginal areas by spreading awareness of modern technologies;
- providing fair reward for the work done and the goods produced by marginal groups and allocating greater resources for food, health, education and housing for the poorest strata;

- in respect of the organisation of the marginal rural groups, promoting development to strengthen their capacity to negotiate in matters of production, distribution and consumption; and

- raising the awareness and organisational capacity of marginal groups so that they can influence the direction of national policies and change the conditions which make possible the excessive accumulation of wealth and the unequal treatment by governmental authorities and institutions.

The above approach made it necessary to envisage two main fields of activity: one which would affect the causes of the economic depression and the internal marginalisation; and the other which would fight against the serious results of a centuries-old marginalisation, which shows itself in rural areas in the form of severe deficiencies in feeding, health, education and in the infrastructure supporting production activities, etc.

Through the COPLAMAR administrative unit, work began on a system of co-ordination, with the participation of the Secretariat for Programme and Budget, aimed at avoiding the dispersal of activities in the marginal areas and at establishing plans to follow up the inter-institutional programmes. Development of these programmes included participation by the communities affected, the use of acquired experience and of the penetration achieved by the institutions belonging to COPLAMAR. At the same time there was set up a System for Programme Co-operation for Depressed Areas and Marginal Groups, on the following basis:

- adoption of agreements between the organisations belonging to COPLAMAR and the federal public administrative authorities;

- territorial integration of projects by planning, execution and evaluation in each area, by the various public institutions with participation by the community and the COPLAMAR regional units, together with supervision by the Committees for the Promotion of Social and Economic Development under the state governors; and

- designation of a non-transferable budgetary allocation to carry through the programmes and projects for the depressed areas and marginal groups.

One should mention that the General Co-ordination Unit for the National Plan for Depressed Areas and Marginal Groups was not an executive body, but rather a promoter of additional activities in the rural areas. On its own it did not make investments, draw up or carry out programmes; these were done only by the competent authorities and institutions within the framework of the sectoral system of the federal public administration.

Until it disappeared in April 1983, the General Co-ordination Unit for the National Plan for Depressed Areas and Marginal Groups entered into various general agreements for programme co-operation with a number of federal public authorities, so that the marginal communities could achieve a minimum of social well-being.

Convention between the Mexican Social Insurance Institute and the General Co-ordination Unit for the National Plan for Depressed Areas and Marginal Groups

To continue extending the scope of the social solidarity services and consolidating a system of community co-operation for the marginal population groups deserving of social solidarity, a Convention was signed in accordance

with the applicable decrees on 25 May 1979 between the Mexican Social Insurance Institute and COPLAMAR, under which the Programme of Social Solidarity through Community Co-operation was established.

Among the considerations contained in the Convention was the following: "In conformity with the Social Insurance Law (inter alia articles 232, 237, 238 and 239) the Mexican Social Insurance Institute is authorised to organise, establish and operate medical units to provide social solidarity services, which are to be made available exclusively to those population groups which, in the present state of development of the country, are deeply marginalised and whom the Federal Government determines as qualifying for social solidarity. Those receiving such services will contribute by cash contributions or by carrying out personal work benefiting the communities in which they live.

In order to fulfil its basic objective, such work must be carried out effectively so that it really provides benefit to the community and it must be efficient, using all available resources, for which it is essential to have a very clear knowledge of the community needs and of the extent and capacity of the human and material resources available in the group receiving social solidarity. The Mexican Social Insurance Institute has therefore considered it essential to co-ordinate with COPLAMAR, set up by the Presidency of the Republic, whose aims and functions are to assist the population groups whose social and economic situation calls for them to be the beneficiaries of social solidarity."

The obligations of the parties to the Convention were the following:

The Mexican Social Insurance Institute undertook:

- to install and operate rural medical units and field hospital clinics;

- to provide the following services in the rural medical units coming under this programme:

  - continuing and integrated measures to promote, protect and restore health;
  - general external consultations;
  - pharmaceutical care;
  - maternity and child care and family planning;
  - health education;
  - nutritional guidance;
  - promotion of hygiene;
  - immunisations; and
  - control of transmissible diseases; and

- to provide the following services in the field hospital clinics:

  - external family medicine consultations;
  - preventive medicine and dental treatment;
  - pharmaceutical care; and
  - external consultations and hospitalisation for basic medical needs.

For its part, COPLAMAR undertook:

- to negotiate with the federal public authorities and institutions as well as the state and municipal governments to obtain support for carrying out community work on programming, the provision of materials, working instruments, food aid, financial resources, etc.; and

- where necessary, to encourage the organisations belonging to it and others capable of organising community work, by entering into specific agreements for the provision of appropriate community services.

CHAPTER II

ESTABLISHMENT OF THE IMSS-COPLAMAR PROGRAMME

Some considerations on the areas covered by the IMSS-COPLAMAR Programme

It is evident that the process of economic, political and social transformation carried through by the revolutionary governments since the 1910 Revolution has run up against internal and external factors which have sometimes helped and sometimes hindered the advancement of the social welfare and justice espoused by the revolutionary movement.

Many people have considered that an important internal factor which had negative effects was the adoption of an economic development policy emphasising industrial growth as a solution to problems. This policy considered that industrial growth would make it possible to absorb the rural population displaced by a static agrarian economy, as the purchase of basic foodstuffs on the international market was cheaper than producing them at home.

This situation led to a growth of the industrial, commercial and service sectors and a considerable stagnation in agricultural development.

Social security, linked with this economic model, was extended over the urban areas, which obviously provided better conditions for setting up a social insurance scheme.

In the 1970s questions were raised about the political approach and the economic model adopted by the country; in particular, there was consideration of reversing the process and stimulating the agricultural sector. For this, three basic measures were adopted, in the form of new laws on agrarian reform, rural credit and social insurance.

The extension of the scheme to population groups in the rural areas met with restrictions inherent in the situation there. In fact, to achieve qualitative change in addition to quantitative growth the process of development had to face serious obstacles, including: the insufficient growth of the basic national infrastructures; the general lack of resources of all kinds; the difficulties in transferring modern technology from the more advanced to the backward areas; the adverse currency exchange rate; and the problems of dependancy resulting from the international economic situation.

Some of the major factors in the situation were: the unfavourable terms of exchange between agricultural and urban products, the methods used for economic, social and rural development, the conditions of environmental health and hygiene, the low technical level and low productivity of the agricultural sector, the land tenancy system and methods of exploitation, the increased population growth, the low priority assigned to agricultural enterprises for the granting of credits and for investment, the isolation and geographical position of the communities and the resulting lack of communications, the variety of languages and cultural patterns, the general state of public health and hygiene, the level of illiteracy, the low incomes, the prevalence of casual work, the limited extent of occupational associations and the operating difficulties in using administrative methods and procedures in line with current needs. The low degree of participation in politics and in economic, social and cultural development also constituted a serious obstacle in the way of bringing the rural communities under social security.

All these factors would have constituted insuperable problems for the extension programmes if one had tried to solve them on the basis of traditional ideas, as in the best possible case it would have been practicable to extend coverage only to a very small degree and only in certain regions, which would have been insufficient even to provide protection keeping pace with population growth.

Traditionally, the rural population has been defined in terms of the economic activity in which it is involved: agriculture, stock-rearing, fowl-rearing and forestry. Another criterion for defining it is the number of inhabitants in each place; thus, it has been considered that the rural population consists of people living in regions with less than 2,500 inhabitants. In Mexico, it is estimated that there are 97,580 localities of which 95,410 have less than 2,500 inhabitants: in these the population is primarily engaged in the above types of activity.

This clear association between occupations in the primary sector and the dispersed population distribution is one of the characteristic features of the concept of marginalisation. Marginalisation consists inter alia of participation of an important section of the economically active population in occupations which are not relevant to the working of the national economy. The process of marginalisation occurs, as in the case of Mexico, when the number of individuals in marginal occupations tends to increase in relation to the total labour force and when their relative contribution to the national production becomes less.

In the broadest sense, the use of the term marginalisation can denote the condition of the population that has remained untouched by the benefits of national development and the wealth created, but has not necessarily been on the margin of the process creating this wealth, and even less enjoying the conditions which make it possible.

This section of the population is in a state of underdevelopment due to the imposition of a capitalist method of production, without a sufficient degree of industrialisation having been attained. The capitalist relationships between the industrialised sector and the underdeveloped sector cause in the latter the destruction of self-sufficient agriculture, without replacing it by another system of production. The traditional agricultural production structure in itself is not a sign of underdevelopment; what does indicate this is when it occurs within a system which generates serious exploitation, corruption or injustice.

In the light of studies carried out in Mexico it is considered that economic progress can be achieved only if there are fundamental changes in the social structures. It is not sufficient to invest large amounts of money and control population growth, but essential to change social relationships and the power structures.

As to the problems inherent in the construction and operation of medical units, account must be taken of experiences of all types in order to arrive at constructive architectural and technical solutions which will both reduce costs and meet the needs of providing a model of medical care appropriate to the cultural characteristics of the population and to its behaviour in terms of demand for services.

Another factor affecting the proper functioning of installations is undoubtedly the availability, training and conditions of employment of medical and paramedical personnel.

The administrative complexity and the high operating costs are further factors, limiting the extension of social security medical services to the rural areas. These problems can be alleviated by a heavier contribution load on those benefiting from development, larger contributions from the Federal Government and the development of a medical care model appropriate to the characteristics of the population covered.

General objectives of the Programme

It is clear that the social security model is a reflection of the development model of the country; any change in the latter will affect the former; hence the need to devote sufficient attention to social changes in relation to the objectives aimed at.

In our country, in recent years, the development process has been seen as aimed at keeping up a growing productive effort, increasing the national product and providing a fairer distribution, these factors taken together necessarily leading to a rise in the standard of living of the majority of the population.

Notwithstanding the clear objectives, our country is in fact developing in an unbalanced way. This situation leads to problems of marginalisation which force us to recognise the existence of an urban Mexico with high economic growth rates and a rural Mexico with clear indications of the secular stagnation that prevails in many parts of the country. It is easy to distinguish in broad outlines those who have from those who have not; that is, the existence of a Mexico that enjoys the benefits of development and the national culture, alongside another which is excluded from both. These differences are particularly acute among the rural population.

This situation led the Government to draw up a global development plan aimed at reversing the process and trying to lessen these sharp differences in order to guarantee a development that would be more balanced and thus fairer.

Social security was included in this approach and a programme was drawn up with the following basic objectives:

- to extend substantially the real coverage of the social solidarity services;

- to establish conditions favouring the effective and efficient use of all resources - both present and future - intended for the social solidarity services, so that they could all benefit the marginal population as a whole; and

- to promote effective participation by the population in local areas in works of benefit to the community.

To achieve these objectives, the programme laid down the following aims:

- to achieve an integrated network of social solidarity services;

- to establish the necessary machinery for co-ordination with the Federal Government in general and with COPLAMAR in particular, in order to guarantee both the acquisition of the financial resources needed by the programme and proper promotion and control of the community benefit activities which it was decided to carry out;

- in health matters, to draw up programmes for activities of benefit to the community under the joint responsibility of COPLAMAR and the Mexican Social Insurance Institute, with the support of the communities themselves; and

- to institute a system of managing the community activities such as would avoid the Mexican Social Insurance Institute having to deal with the problems of individual control over entitlements and to make it easier for the Institute's medical and paramedical staff to be free of the administrative responsibilities which are not part of their essential functions and thus to devote all their efforts and capacities to preventive activities, improvement and maintenance of the health of the members of the communities.

Establishment of the IMSS-COPLAMAR Programme

In the above situation, fundamental decisions had to be taken and strategies drawn up to solve the problem of medical care for the marginal groups; as already mentioned, this formed part of the global development plan and involved activities which it was thought would influence both the causes and the immediate effects of marginalisation.

Administration of the IMSS-COPLAMAR Programme

In order to speed up the extension of medical services to marginal areas on a sound basis of administration, organisation and control such as would ensure the programme's efficiency, a very important decision had to be taken on the choice between three alternatives: first, to create a new and distinct body to be responsible for administering all aspects of the programme; second, to entrust its administration to the traditional health care system; or third, to incorporate it in the legal and administrative structure of the Mexican Social Insurance Insitute.

- Creating a new and distinct organisation would have raised considerably the operating costs; it not be easy to find the specialised staff to ensure the programme's efficiency; and the inclusion of such a new body within the framework of the federal administration would require legal and administrative reforms which would hold up matters.

- If the Mexican State took over responsibility for meeting from its own budget the requirements of social assistance including medical attention to poor persons through the Health Secretariat, this would have given the medical care an assistance aspect which would not have affected the causes of poverty, but only its most immediate effects; thus it would not be able to overcome the weak social situation of those concerned but would simply consist of palliative measures, not in accordance with the concept of social solidarity preached by the State itself.

- Incorporating the programme in the legal and administrative structure of the Mexican Social Insurance Institute was the most appropriate solution. The advantage of this choice lay in the use of an administrative structure whose efficiency had already been fully demonstrated.

The Mexican Social Insurance Institute had administrative, technical and scientific staff trained to carry out the programme with the speed required. Thanks to its ability to obtain its own resources, it had the financial basis

immediately available, in that the Federal Government would make the appropriate transfers of funds in accordance with the established procedures.

Carrying out this decision required the adoption of strategies to guarantee within a short space of time the achievement of both quantitative and qualitative objectives.

The administration of the programme of extension of medical services to marginal areas was based on the system of administrative decentralisation effective in the Mexican Social Insurance Institute, under which the responsibility for operating the programme was entrusted to its state and regional delegations. Local management was based on human, material and financial resources and was subject to the rules and regulations established for medical care provided to insured persons.

The process of planning and the determination of administrative and operational rules governing the programme were kept at the central level, being put in the hands of a specific body set up to co-ordinate the plans and activities of the various operating sectors of the Mexican Social Insurance Institute which supported the programme: the constructions and maintenance sector, the medical services sector, the preventive medicine sector, the supply sector and the financial control sector. This organ, which was called the General Co-ordination Unit for the IMSS-COPLAMAR Programme, was formed of personnel from the different sectors in the Institute, who thus knew its operating mechanisms and were familiar with technical aspects and regulatory standards.

The administrative process which, on the one hand, brought under central control the planning, the determination of rules and standards and the co-ordination and, on the other hand, decentralised the operation, was based on an effective system of supervision and control at three levels: central, co-ordination level and delegation level.

- The central level was the responsibility of the General Directorate of the Mexican Social Insurance Institute and its subdirectorate of finance, covering administration of the financial resources allocated by the Institute to the IMSS-COPLAMAR programme.

This high-level control body was the one charged with defining the criteria for establishing and controlling the budget of the Mexican Social Insurance Institute, in accordance with the general lines laid down by the Secretariat for Programming and Budget, the body entrusted by the Federal Government with administrative and financial control over the national budget.

The second level of supervision and control was the responsibility of the General Co-ordination Unit of the IMSS-COPLAMAR programme. This acted at the central level, supervised strict compliance with rules and controlled the activities of the central sectors involved in the programme and also at the level of delegations, by direct supervision of compliance with the rules of the Institute, coupled with supervision on a planned or by exception basis carried out by multidisciplinary teams visiting the operational units.

- The third level was that of the state and regional delegations of the Mexican Social Insurance Institute, which brought into the framework of its routine operating and control arrangements all the activities related to the IMSS-COPLAMAR programme.

At this level, and also directly in the operating units, the staff coming under the delegation administratively and under the General Co-ordination Unit at the central level for the application of standards and regulations, carried

out a supervision whose main feature was permanent advice and training for the operating personnel, in order to ensure compliance with standards and to a large extent to guarantee the quality of the medical care provided.

The model of medical care

For the provision of medical services under the IMSS-COPLAMAR programme a system was set up based on levels of care, with the emphasis on preventive activities and with the allocation of the resources needed for each sector covered.

The system was based on three levels related to the priorities and to the resources and technical facilities available. The first level designed to solve frequently arising health problems which require simple techniques and are linked with active participation by the community. Most of the services are provided at this level, there is direct contact between the doctor and patient and the health activities are made available to all those living in the area covered by each of the medical care units, referred to as rural medical units. One can say that 85 per cent of the demand for medical care is handled at this level.

Given the level of knowledge, organisation and penetration achieved by the General Co-ordination Unit for the National Plan for Depressed Areas and Marginal Groups in the areas where it was operating, it was possible to organise, promote and carry out community improvement programmes which involved the users of the medical services; these covered health education and preventive medicine programmes applied directly by the Mexican Social Insurance Institute through its Office for Preventive Medicine Services.

The promotion of community work also linked the IMSS-COPLAMAR programme with othr government programmes related to the provision of food to marginal areas, the introduction of drinking water, irrigation and access roads, vocational training and extra-school education, which also required community work by the users of the medical services.

The second level consisted of basic services in the following fields: internal medicine, surgery, paediatrics and gynaecology-obstetrics, which all require more complicated technical facilities. This second level was provided through field hospital clinics having available the specialised services, hospital accommodation and diagnostic facilities (laboratories for clinical analyses and X-rays). These were made available to patients referred by the rural medical units which formed part of regional networks in which basic health and preventive medicine programmes are also carried out. Twelve per cent of the demand for care is handled at this level.

The third level is that of highly specialised medical services which are provided only in the major urban centres and which meet 3 per cent of the demand for care. This level does not operate through the IMSS-COPLAMAR programme, except that, by institutional co-operation with the Health Secretariat, it is made available in highly specialised hospitals which come under the Secretariat. The technical criteria governing the location, selection, and establishment of first-level medical care units were related mainly to the following characteristics:

In order to provide an appropriate and efficient service, it was stipulated that the units should be in accessible localities which were centres where activities were concentrated - religious, commercial, educational, etc.; in addition, the population had to be considered as

predominantly marginal. This led to establishing the population range of between 500 to 2,500 inhabitants.

The units had to be placed in localities where there was no existing health resource either similar to or better than what was proposed, so as to avoid duplication of efforts. It was also desirable to have drinking water and electricity in order to provide a more efficient service.

As for the area covered by the rural medical unit, one had to bear in mind that although a population of 5,000 persons on the average was considered appropriate, it was also necessary to take into account that because of the isolation and inaccessibility of some regions one could establish a lower limit of about 2,500 inhabitants, whereas the upper limit should not exceed 8,000.

In support of this, it was considered that a universe of this population size would make it possible to obtain sufficient human resources to provide the medical and auxiliary staff.

Both the need to get medical care rapidly and the work of health promotion and specific protection require close and sustained contact between the population and the health centre, so that it was desirable that the localities covered by the rural medical unit should not be more than 60 minutes travel time away.

For the field hospital clinics, the Mexican Social Insurance Institute decides on and carries through a process designed to ensure that their installation meets the requirements of providing integral health services in areas that do not have these as well as providing support to most of the rural medical units operating.

It has been decided that the field hospital clinics shall provide the following as integrated services in each unit: general medicine, internal medicine, general surgery, paediatrics, gynaecology and obstetrics, dental care, X-rays, pharmacy and laboratory services.

Also, the place in which a field hospital clinic is situated must have a population of not less than 5,000 and not more than 10,000 persons; there must be two or more roads for communication, preferably surfaced or in hard earth; there must also be water, lighting and sewerage, which are all essential for a hospital to operate. It is also advisable that there should not already be a health facility similar to or better than that which is being proposed.

The area covered by a field hospital clinic contains approximately 40 rural medical units.

Out of the broad range of medicaments that are in the basic list of the Mexican Social Insurance Institute, the Programme has specified a standard basic provision for the rural medical units and the field hospital clinics; this is based more on financial concerns than on the regional pathology characteristics. The approach is to try to avoid providing unnecessary medicaments not in common use and to provide those which match the regional epidemiological profile.

Characteristics of the staff

One of the most serious problems that was faced and is unfortunately still being faced in extending the medical services to marginal areas is the tendency of medical staff to want to stay in towns and cities.

The Mexican Social Insurance Institute has drawn up a strategy aimed at solving this problem by setting up a system of recruitment, selection and training of medical staff which could well be termed an institutional medical career system.

In Mexico, medical students must perform one year's social service to obtain their medical qualification and certificate. This service must be carried out somewhere in the country and must be agreed upon by a health institution.

Recruitment for the medical staff of the rural medical units begins when the General Co-ordination Unit of the IMSS-COPLAMAR programme sends to the head office of the Teaching and Research Services of the Mexican Social Insurance Institute the report on the positions needing to be occupied. Under an agreement with the medical schools, endorsed by the Health Secretariat, the Mexican Social Insurance Institute decides by drawing lots which positions are to be filled by those performing social service. Once the staff have been designated, they undergo a brief on-the-spot training course and are assigned to the appropriate rural medical unit. There, the doctor carries out his social service under the constant supervision of a medical auxiliary adviser. The permanent advisory body is assisted by a series of technical manuals which guide it in carrying out its work.

The auxiliary nursing staff of this Programme has one special feature. Two young persons are selected from each locality where there is a rural medical unit: they must have completed primary or secondary school and be bilingual in the case of indigenous communities. They undergo a training course in an area hospital of the Mexican Social Insurance Institute for two months and the one who is best qualified obtains the main position, whilst the other is given a special contract for covering absences, vacations and rest days.

This paramedical personnel receives continuous training from the social services doctor in all the auxiliary work to be done in the medical area.

There is one particularly important aspect of the functions carried out by the staff aiding the doctor, who is generally not a local person. This arises from the need to take account of the cultural values and attitudes of the local population in relation to health, medicine and hygiene; there is also the essential translation work. This guarantees continuity in community work on health matters, as this staff is on indeterminate contracts whilst the doctors are on contracts limited in time.

The positions that for various reasons are not covered in the above manner are occupied on the basis of temporary contracts with doctors who are practising privately or performing replacement duties in the Institute. Thus, there is always a doctor present in the Unit.

Once the social service stage is completed, the General Co-ordination Unit of the IMSS-COPLAMAR Programme recruits those doctors who have best performed their duties and offers them contracts as advisers or medical assistants for supervisory and advisory functions.

After having functioned for a year as auxiliary medical advisers, they take examinations to obtain the family medicine residency qualification. During this period the postgraduate serves in a field hospital clinic either belonging to the IMSS-COPLAMAR Programme or forming part of an insurance scheme for rural groups. After one year of professional work in field hospital clinics and completing the residency, the doctor is sure of obtaining a job as a family doctor in the Mexican Social Insurance Institute and in a town or city.

This is the broad outline of the institutional career which encourages doctors to work in marginal areas for at least three years.

The provision of human resources for a field hospital clinic whose installed capacity varies between 25 and 70 beds also includes a governing body composed of a director, who is a general surgeon, an administrator, a chief nurse and a resident maintenance officer.

The rest of the personnel consists of the resident doctors mentioned, doctors performing their social service, postgraduates in internal medicine, odontology, chemistry, nurses and social workers, all forming part of the social service; in addition, there is auxiliary local medical personnel, plus those responsible for administration, diagnosis, maintenance and general services. One may observe that these field hospital clinics are real training centres for the staff for the various sectors of the ordinary urban scheme, with the advantage that during this field apprenticeship many of those involved acquire a new attitude towards social medicine as compared with that of doctors who have generally been trained under the philosophy of a competitive liberal medicine.

The Medical Co-ordination Unit of the IMSS-COPLAMAR Programme defined the contents of the educational model to be applied to these doctors. Emphasis was laid on subjects of major importance and included medical and social anthropology, preventive medicine, family planning and programmes related to the medical care of peasant and indigenous families.

Determination of localities to be covered

The IMSS-COPLAMAR Programme made it possible for the benefits of the social solidarity programmes to reach out to an increasing number of peasant and poor families, through the extensive assistance network provided by the medical units.

The need to provide services and in general the need to solve the health problems in the marginalised areas led the State to decide to broaden the scope of coverage of the Programme, with the construction of a very large number of rural medical units and field hospital clinics. It was also decided to revise the scope of coverage of the health assistance scheme by integrating with the IMSS-COPLAMAR Programme the health centres operated in rural areas by the Health Secretariat; this was aimed at having health resources available to protect the entire rural population of the country.

Organisation and operation of the committees for health and promotion of community work

COPLAMAR is responsible for promoting the integration of the committees for community work in the various fields of activity which it covers. Similarly, it is responsible for checking compliance with the programmes of units under the Federal Government and the State Governments. For health and

hygiene matters, the Mexican Social Insurance Institute has assumed the responsibility of promoting the necessary community work and establishing an adequate record of this for inclusion in the general reports which COPLAMAR is required to submit. To achieve this, the doctors of the Mexican Social Insurance Institute responsible for the rural medical units have to set up health committees under the IMSS-COPLAMAR programme, both in the localities where their own units are and in those other places which are within their area of influence, in line with the decrees laying down who is entitled to benefit from social solidarity.

The members of the health committees work in the community on an equal basis in promoting, planning, budgeting and organising activities related to health both on their own initiative and in line with what the community assembly and the Mexican Social Insurance Institute have jointly decided.

The health committee functions as promoter of community needs among the various municipal, state and federal authorities who are engaged in activities related to health.

It also draws up jointly with the medical and paramedical personnel of the Mexican Social Insurance Institute an annual schedule of their activities, which includes inter alia periodical meetings for training, information and advice on carrying out their specific functions.

The doctor responsible for the rural medical unit makes a record of the activities of the health committees and of the days of community work performed, or their equivalent, for the communities; and submits the relevant report to the representative of the Mexican Social Insurance Institute in the State, on the date required; the latter in turn transmits it to the representative of COPLAMAR.

Priority programmes

In the medical units of the National Social Solidarity Programme, which consists of the IMSS Social Solidarity Programme and the Programme of Social Solidarity through Community Co-operation (IMSS-COPLAMAR), programmes have been developed for preventive care, remedial care and popular training. These have been subdivided into the following nine sub-programmes:

Programmes	Sub-programmes
Preventive care	Control of preventable diseases by vaccination
	Control of transmissible diseases
	Early detection of illness
	Voluntary family planning
	Oral health
Remedial care	General external consultations
	Specialised external consultations
	General hospitalisation
Popular training	Health education

These programmes and sub-programmes are developed under the standards and procedures laid down by the general medical sub-directorate of the Mexican Social Insurance Institute through its offices for medical services, preventive medicine and family planning.

Budget, financial and capital aspects

The role of the public budget as an instrument of income redistribution is all the more important when it is applied directly to the production and distribution of goods and services for the population. Based on this approach, the López Portillo regime expanded care programmes for the marginal population and those with scanty resources, through the existing institutional structures, with the aim of avoiding excessive administrative expenses which would have resulted from setting up special operating bodies.

To achieve the objectives set by COPLAMAR, the starting point was that each of the depressed areas or marginal groups was facing different difficult situations which had to do with both security and the guarantee of individual and social rights, as well as the characteristics of the physical environment and the structure of economic relationships. Among the social welfare factors which COPLAMAR had to tackle were feeding, housing, education, health and environmental hygiene.

The income distribution structure was looked at more critically in terms of the access to consumer goods and services, particularly for the marginal population. Hence the distribution strategy adopted by the State was aimed

both at the creation of employment and at other economic and social measures. Emphasis was laid on price stability and increasing productivity. However, in view of the limited effect of economic measures in isolation, social measures were also included. These programmes were aimed at the direct production of services making access by the population to minimum levels of welfare easier.

It was thought that social marginalisation could be overcome only as the result of an action of such broad scope that it was beyond the possibilities offered by isolated action by any part of the federal public administration. On the other hand, the operations of COPLAMAR made it possible to co-ordinate the activities of various bodies under a combined plan, which led to the development of a system of planned co-operation subdivided into three basic elements:

- The adoption of conventions between the bodies forming part of the Co-ordination Unit and the other subordinate bodies of the federal public administration. The former brought their professional and technical experience, their territorial penetration, their permanent contact with communities and an integrated approach to the needs, together with human and material resources. The latter brought their capacity for planning, execution and operation on all matters within their scope, together with their human and material resources.

- The territorial integration of projects by planning, carrying out and evaluating them in each area on the part of the different public institutions, working publicly with community participation, together with the regional units of COPLAMAR and under the supervision of the Social and Economic Development Promotion Committee (COPRODES).

- The establishment of a non-transferable budgetary allocation for the programmes agreed upon and for the projects drawn up by the various institutions and units concerned with the depressed areas and marginal groups: this allocation to be available to the institutions responsible for carrying out the programmes.

It was thought in Mexico that social security could have its major redistributive effects through the social solidarity schemes which benefited the largest possible number of people.

Under the Social Insurance Law, the social solidarity programme of the Mexican Social Insurance Institute, which has been in operation since 1975 under presidential agreement, provides for 40 per cent of the operating expenses to be met by the Institute from its surpluses and the remaining 60 per cent to come from the Federal Government.

When the IMSS-COPLAMAR Convention was signed, in order to speed up the extension of the services, the Federal Government decided to meet 100 per cent of the budget allocated to the Programme.

The high priority attached to this Programme by the Federal Government has meant that there has been great flexibility in the release of budgetary funds for its investment and operating costs.

CHAPTER III

DEVELOPMENT OF THE IMSS-COPLAMAR PROGRAMME

The new legal framework of social solidarity

On 20 April 1983 the Federal Government issued a decree under which, with the disappearance of COPLAMAR, the Institute took over full responsibility for the programme, which implied organising community participation on the basis of the social insurance law, that is as a counterpart to the services received, with special attention paid to the activities which directly influence the state of health of the population and improve the family and community environment.

In 1983 there was also published the National Development Plan for 1983-88 and on 8 March 1984 the Official Gazette published the Decree on Decentralisation of the Health Services for the population as a whole. On 10 July 1984 the General Health Law came into force. These legal arrangements contain provisions governing the activities of the IMSS-COPLAMAR Programme which, together with those contained in the IMSS Law, the Planning Law and other laws on health matters form the legal framework for the Social Solidarity Services.

The current situation of the IMSS-COPLAMAR Programme

At the present time the IMSS-COPLAMAR Programme rests on two basic elements: health care and community action.

Health care

Until 1985 the operation of the IMSS-COPLAMAR Programme was based on 3,246 first-level units and 65 "S-type" rural hospitals at the second level. These resources covered a population of 13,896,142 individuals in the 31 federal territorial units.

In the last quarter of 1985 and the first quarter of 1986 the health services of the IMSS-COPLAMAR Programme were decentralised to 12 state governments, so that during 1986 the Programme operated in 19 federal sections with a total of 2,404 first-level units and 50 "S-type" rural hospitals which form the second level of care, covering a population of 9,544,258 registered with these units.

The programme for decentralising the IMSS-COPLAMAR Programme to the state governments was slowed down in order to assess its operation in the States concerned and study the question of whether it was appropriate for this process to continue or not. In the year 1986, the General Co-ordination Unit of the IMSS-COPLAMAR Programme pushed forward with consolidation of the health services of the 19 federal sections in which the IMSS-COPLAMAR Programme was operating, revising its strategies to apply fully the integral health care model and the Institutional Health Development Programme; in this way, during 1986 the IMSS-COPLAMAR Programme attended its health services by using trained human resources in the community and rural health technicians, rural health assistants or voluntary rural health promoters.

Quite a number of the units of the IMSS-COPLAMAR Programme are in small isolated communities of less than 500 inhabitants, where the lack of communication prevents integration in the national development process. These are therefore places where there is a lack of services, shortage of personnel, absence of basic hygiene and an epidemiological picture in which transmissible diseases predominate.

As a result of this the environment is hostile to visiting doctors, whose social background and training have been in urban areas: they frequently resist carrying out their year of social service in this type of place. For the IMSS-COPLAMAR Programme the result is naturally a shortage of visiting doctors in the rural medical units.

It has thus been observed that there are quite a number of units which have permanent problems in finding visiting doctors or which meet with frequent refusals.

Furthermore, the professional medical staff assigned to them is generally under-used, which means that, because of their academic level and lack of knowledge of the local culture, they are not able to identify and communicate fully with the local population.

Faced with this problem the General Co-ordination Unit of the IMSS-COPLAMAR Programme and the General Medical Sub-directorate, operating through the Chief of the Education and Research Services, decided on the training of auxiliary technical staff. The rural health technician is trained to acquire skills and knowledge which enable him, when there is no doctor, to carry out educational work, promote community participation in solving health problems and provide medical care for a limited number of frequent illnesses, drawing on a basic list of specific medicaments. The practical medical duty of these technicians is to diagnose what is clear to them, limit health impairment, recognise complaints which require the attention of more highly-trained persons and refer them as appropriate to the nearest field medical unit for treatment.

In this way, an effort is being made to provide the rural medical units which are difficult of access or cover only a small population with stable human resources technically able to provide primary health care and who, being themselves from the local community, identify fully with the regional social and cultural patterns.

The rural health technicians are trained in the following subjects:

- philosophy, objectives and organisation of the programme of social solidarity through community co-operation;
- the importance of participation by the community in solving its health problems;
- the bases of primary health care;
- method of drawing up a health diagnosis;
- elementary terminology in health matters;
- health activities needed in connection with pregnancy, confinement, post-natal treatment and family planning;
- health activities required in supervising the growth and development of children, taking into account their age, sex and physiological condition;

- activities required to promote suitable nutrition, with emphasis on the high-risk groups, pregnant women and children aged under five;

- identification of the population at risk of preventable diseases for the purpose of vaccination and knowledge of the techniques of applying appropriate biological treatment;

- importance of and procedures for carrying out early detection, prevention and treatment of the main local diseases, as well as of injuries and medical emergencies of a type that is frequent;

- health problems in which they should not intervene, as they need care at another level;

- guide-lines for appropriate referral of patients to the nearest support unit;

- importance and techniques of environmental hygiene for families and the community;

- techniques of integration and group management necessary for health promotion activities;

- administrative procedures for the provision of services, routing of patients and information systems.

As the country is far from achieving total coverage of the rural population through the social solidarity services, the General Medical Sub-directorate, acting through the Chief of the Education and Investigation Services and the General Co-ordination Unit for the IMSS-COPLAMAR Programme, has arranged for the training of human resources to provide the link between the patient, the community and the health care system. At the same time, they should meet the real community health needs and assume responsibility for the activities designed to widen the coverage of services to improve the quality of primary health care in the areas covered by the rural medical units.

In 1984 courses were started for the training of rural health assistants. At present 829 persons have completed these courses: they are now located in their own communities and are carrying out the work for which they were trained.

Up to the present the results have been satisfactory. Experience both in developing the courses and in the work done by the assistants has made it possible to amend the original programme in such a way as to increase the quality of the graduates and improve their effectiveness within the integral health care model of the IMSS-COPLAMAR Programme.

The courses for the training of rural health assistants have the following objectives:

- to train one or two rural health assistants for each of the field medical units of the IMSS-COPLAMAR Programme;

- to bring into the health team of the field medical units human resources capable of comprehending and seeing to the common and elementary health needs of the community;

- to have available human resources coming from and living in the places where they work, technically capable of carrying out prevention and health promotion activities;

- to have available human resources capable of managing, organising and training groups within the community to achieve their participation in the solution of their problems; and

- to have human resources that can advise the inhabitants of the places within the area of intensive action of the field medical units, in carrying out work and services for improvement of the family and community environmental hygiene.

The rural health assistant is trained in the following:

- the bases of primary health care;

- the organisation of the IMSS-COPLAMAR Programme;

- administrative procedures in the provision of services;

- elementary terminology used in the health area;

- teaching techniques;

- the bases of personal hygiene and of family and community environmental hygiene;

- carrying out surveys to co-operate in achieving local health diagnoses;

- programmes of health education;

- recognition of the symptoms and signs of danger that occur in the diseases, injuries and intoxications that are most frequent in the community;

- structure and dynamics of the community; and

- techniques applying the different vaccines.

The voluntary rural health promoters, who are the operating arms of the health committees and are directly responsible for taking part in supervising and looking after the health and welfare of a group of families, including their own, have increased in number and now total 47,326.

Community action

The fundamental principle of community participation is the organisation and training of individuals for carrying out work or work-day that they have to contribute as a counterpart to the health care services that they receive, which are provided entirely free of charge for the recipients of social solidarity. The starting point is the individual and family acceptance of the need to look after their own health, personal hygiene, cleanliness and housing improvement.

Great importance attaches to activities concerned with: proper management of water for human consumption; the sanitary disposal of excreta and waste, housing improvement, use of latrines; family fruit and vegetable gardens; rearing of small fowls and animals and the participation in collective community improvement duties in fields such as: roads, paths, access, schools and public buildings. This community participation is fundamental; without participation of its members as a whole it is difficult to improve the health conditions in an inhabited locality.

There has in fact been a good increase in community participation in these activities, the number of families participating having doubled as compared with 1985.

As part of these activities the most important ones are those concerned with human excreta, sanitary disposal of waste and rubbish, close attention to drinking water and activities concerned with harmful fauna.

As will be seen, the main institutional objective of the IMSS-COPLAMAR Programme today is the promotion of health development and raising the quality of life of the marginal rural population. The social participation must be voluntary, organised and continuous in the task of identifying and altering the determining factors that adversely affect health, alongside carrying out activities that improve individual, family and community welfare.

Statistical information

With the support of the staff of the institution and people from the communities, together with the physical and technical resources allocated during 1986, the IMSS-COPLAMAR Programme achieved the majority of its objectives. In that year the total persons involved were the staff of the IMSS (10,664 persons), 47,326 voluntary rural social health promoters, 829 trained rural health assistants, 10,056 traditional healers and the members of the 8,591 active health committees and 562 municipal health committees. With all these persons working in the field of health the population covered by the programme in 1986 reached 9.54 million individuals entitled to benefit from solidarity; they were given 4,221,214 consultations and care on the occasion of 21,682 births, in the first-level medical care units. In the rural hospitals there were 1,059,374 family medical and dental consultations, as well as 351,318 specialist and emergency consultations; in this context, the following figures were recorded for the rural hospitals during the year: 101,094 discharges, 47,768 surgical operations, 41,945 births, 847,687 laboratory examinations and 169,947 X-ray examinations.

In this context the figure for hospital discharges during the last three years is significant, as it increased by 40 per cent, which confirms the better range and acceptance of the services, the higher quality of medical care provided and the greater capacity of these hospital units.

As for prevention and health promotion activities, in all the medical units of the system there were 8,057,329 doses of biological products, preventive dentistry was provided for 630,846 persons, there were 2,615,920 detections of chronic degenerative diseases, 285,098 sessions of health education, attended by a total of 4,263,866 persons; and 430,432 family treatments were provided. A total of 1,017,379 children were examined for malnutrition; of these 34.03 per cent were diagnosed as undernourished (346,250) and of them 47.76 per cent of the children treated were cured using the family's own resources.

The voluntary family planning, especially for mothers at risk in case of pregnancy, covered 15,831 women.

Through the community organisation - particularly the health committees and the rural health promoters - the communities were stimulated to press forward with environmental hygiene and housing improvement activities, acting on the main causes lying at the root of respiratory and digestive complaints. Nevertheless, in spite of the progress achieved, these still are an important source of illness and death in the rural areas. Using its own resources and in some cases with the support of those provided by the Secretary for Urban

Development and Ecology, the communities - employing techniques and construction materials fitting in with the cultural features of the locality - achieved the following in 1986:

38,992 Measures to protect and clean the sources of water supply.

53,996 Public works for the sanitary disposal of human excreta.

18,228 Public works for the sanitary elementation of waste and rubbish.

29,456 Public works for the control of harmful fauna and vectors.

Alongside the activities of the nutritional centres, stimulus was given to the local production of food, which encouraged the establishment of 96,185 family or communal fruit and vegetable gardens and 78,392 buildings for rearing small fowl and animals.

In the housing field, the work of the programme included 399,300 improvement tasks, representing an increase of 41.4 per cent compared with 1985.

All this work, taken together with that of previous years and the sustained effort to provide health education, mean that by the end of 1986 there were:

366,148 Families making proper use of water for human consumption.

313,170 Families with sanitary disposal of their excreta.

397,625 Families with proper elimination of waste and rubbish produced in the home.

589,851 Families participating in the production of foodstuffs to supplement their diet.

704,188 Families participating in the control of harmful fauna and vectors.

Compared with the total families coming within the scope of work of the Programme, the number participating in the above priority activities reached 24 per cent, which was 11 per cent more than in 1985. Thus, the falling trend in participation during the period 1984-85 was reversed in 1986. The level achieved is adequate if we consider the difficulties involved in rural communities in changing ancestral habits and customs prejudicial to health, especially when the change proposed is based on the voluntary co-operation of the population, which decides whether or not it will carry things out in practice.

As for alcoholism, during 1986 there were 14,571 sessions on prevention and control; 20,187 new cases of this disease were noted, practically half of them being on the occasion of treatment for complications arising from alcoholism; and 4,431 joined existing alcoholics anonymous groups. At the same time, 721 new self-help groups were set up which, together with the 1,001 formed in 1985, brought the total groups in operation to 1,722.

An important part of the Programme's work has been the encouragement of formation of social promotion groups. Their number increased during this period. They deal with health improvement measures in the field of literacy, recreation and culture, all of which contribute to family well-being and to improvement in the quality of life. In addition, together with the Mexican Social Insurance Institute General Co-ordination Service for Social Benefits,

community health development centres were organised on the premises of the rural hospitals in Rincón de Romos, Aguascalientes and Guadalupe Victoria, in the State of Durango. Here, in addition to the health promotion and protection activities, there are cultural and recreational activities and training in arts and crafts which help to protect or increase the family income. This experience is now beginning to be extended to the other hospitals. Finally, in co-ordination with the Social Promoters' Unit of the Mexican Social Insurance Institute, steps were taken for the community to build seven new hostels in rural hospitals which lacked them; together with the ten already existing, this made a total of 17. This means that 35 per cent of the rural hospitals have a place where the community can provide its support, feeding and looking after the families of the patients in hospital where they require it. Construction has also begun on ten more hostels in a similar number of the Programme's hospitals.

The IMSS-COPLAMAR Programme works together with the 1983-88 National Development Plan and with the National Health Programme, in the effort to improve the national level of health, particularly for those sectors disadvantaged by unbalanced social development, stimulating self-help and the promotion of conditions that can improve the individual and community health levels by means of educational and health activities. This forms the most effective instrument available to the regime in moving from the present society to a more egalitarian one.