# Report card

## Mexico

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Obesity prevalence

Adults, 2016

Survey type: Measured
Age: 20+
Sample size: 8412
Area covered: National
References: Encuesta Nacional de Salud y Nutrición de Medio Camino 2016

Unless otherwise noted, overweight refers to a BMI between 25kg and 29.9kg/m², obesity refers to a BMI greater than 30kg/m².
Children, 2016

Survey type: Measured
Age: 12-19
Sample size: 2581
Area covered: National


Notes: WHO Growth Ref Standard
Cutoffs: WHO
% Adults living with obesity in Mexico 1992-2016

Survey type: Measured

References: For full details of references visit https://data.worldobesity.org/

Unless otherwise noted, overweight refers to a BMI between 25kg and 29.9kg/m², obesity refers to a BMI greater than 30kg/m².

Different methodologies may have been used to collect this data and so data from different surveys may not be strictly comparable. Please check with original data sources for methodologies used.
% Adults living with overweight or obesity in Mexico 1992-2016

Survey type: Measured

References: For full details of references visit https://data.worldobesity.org/

Unless otherwise noted, overweight refers to a BMI between 25kg and 29.9kg/m², obesity refers to a BMI greater than 30kg/m².

Different methodologies may have been used to collect this data and so data from different surveys may not be strictly comparable. Please check with original data sources for methodologies used.
Overweight/obesity by education

Women, 2012

- Primary or no education
- High school only
- Secondary
- Higher education

Survey type: Measured
Age: 20-49
Sample size: 4943
Area covered: National
Notes: Obesity Prevalence based on Education level in Rural areas

Unless otherwise noted, overweight refers to a BMI between 25kg and 29.9kg/m², obesity refers to a BMI greater than 30kg/m².
Overweight/obesity by age

Children, 2016

Survey type: Measured
Sample size: 5765
Area covered: National

Cutoffs: WHO
Overweight/obesity by region

Women, 2012

Survey type: Measured
Age: 20-49
Sample size: 14531
Area covered: National


Unless otherwise noted, overweight refers to a BMI between 25kg and 29.9kg/m², obesity refers to a BMI greater than 30kg/m².
Children, 2006

Survey type: Measured
Age: 5-11
Sample size: Children aged 5-11yr: n=15111
Notes: Overweight and obesity were classified according to IOTF criteria, based on BMI measurements, with cutoff points for BMI based on an international reference population drafted from seven countries, specific for age and sex. Said cutoff points are a projection of the criteria proposed by WHO for diagnosing overweight (BMI of 25-29.9) and obesity (BMI of 30 or more) in adults.

Cutoffs: IOTF
Overweight/obesity by socio-economic group

Adults, 2009-2010

Survey type: Measured
Age: 50+
Sample size: 2032
Area covered: National


Notes: Prevalence of obesity in older Mexican adults (50+)

Unless otherwise noted, overweight refers to a BMI between 25kg and 29.9kg/m², obesity refers to a BMI greater than 30kg/m².
Children, 2006

Survey type: Measured
Age: 5-11
Sample size: Children aged 5-11yr: n=15111


Notes: Prevalence of overweight and obesity by Socioeconomic Level. Overweight and obesity were classified according to IOTF criteria, based on BMI measurements, with cutoff points for BMI based on an international reference population drafted from seven countries, specific for age and sex. Said cutoff points are a projection of the criteria proposed by WHO for diagnosing overweight (BMI of 25-29.9) and obesity (BMI of 30 or more) in adults.

Cutoffs: IOTF
Insufficient physical activity

Adults, 2016

Men, 2016

Women, 2016

Estimated per-capita fruit intake

Adults, 2017

Survey type: Measured
Age: 25+
References: Global Burden of Disease, the Institute for Health Metrics and Evaluation [http://ghdx.healthdata.org/]
Definitions: Estimated per-capita fruit intake (g/day)
### Estimated per-capita processed meat intake

**Adults, 2017**

<table>
<thead>
<tr>
<th>Country</th>
<th>Per Capita Processed Meat Intake (g/day)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Haiti</td>
<td>16</td>
</tr>
<tr>
<td>Bolivia</td>
<td>15</td>
</tr>
<tr>
<td>Peru</td>
<td>14</td>
</tr>
<tr>
<td>Nicaragua</td>
<td>13</td>
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<tr>
<td>Guyana</td>
<td>12</td>
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<tr>
<td>Belize</td>
<td>10</td>
</tr>
<tr>
<td>Jamaica</td>
<td>10</td>
</tr>
<tr>
<td>Guatemala</td>
<td>9</td>
</tr>
<tr>
<td>Cuba</td>
<td>9</td>
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<tr>
<td>El Salvador</td>
<td>9</td>
</tr>
<tr>
<td>St Vincent &amp; Gren.</td>
<td>8</td>
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<tr>
<td>Dominica</td>
<td>8</td>
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<tr>
<td>St Lucia</td>
<td>7</td>
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<tr>
<td>Grenada</td>
<td>7</td>
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<tr>
<td>Colombia</td>
<td>7</td>
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<tr>
<td>Dominican Republic</td>
<td>7</td>
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<tr>
<td>Suriname</td>
<td>7</td>
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<tr>
<td>Venezuela</td>
<td>6</td>
</tr>
<tr>
<td>Barbados</td>
<td>6</td>
</tr>
<tr>
<td>Antigua &amp; Barbuda</td>
<td>6</td>
</tr>
<tr>
<td>Costa Rica</td>
<td>5</td>
</tr>
<tr>
<td>Brazil</td>
<td>5</td>
</tr>
<tr>
<td>Panama</td>
<td>5</td>
</tr>
<tr>
<td>Brazil</td>
<td>5</td>
</tr>
<tr>
<td>Trinidad &amp; Tobago</td>
<td>5</td>
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<tr>
<td>Argentina</td>
<td>5</td>
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<tr>
<td>Ecuador</td>
<td>5</td>
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<tr>
<td>Uruguay</td>
<td>5</td>
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<tr>
<td>Mexico</td>
<td>5</td>
</tr>
<tr>
<td>Chile</td>
<td>5</td>
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<tr>
<td>Canada</td>
<td>5</td>
</tr>
<tr>
<td>United States</td>
<td>5</td>
</tr>
</tbody>
</table>

**Survey type:** Measured

**Age:** 25+

**References:** Global Burden of Disease, the Institute for Health Metrics and Evaluation [http://ghdx.healthdata.org/](http://ghdx.healthdata.org/)

**Definitions:** Estimated per-capita processed meat intake (g per day)
Estimated per-capita whole grains intake

Adults, 2017

Survey type: Measured

Age: 25+

References: Global Burden of Disease, the Institute for Health Metrics and Evaluation [http://ghdx.healthdata.org/]

Definitions: Estimated per-capita whole grains intake (g/day)
Mental health - depression disorders

Adults, 2015


Definitions: % of population with depression disorders
Mental health - anxiety disorders

Adults, 2015


Definitions: % of population with anxiety disorders
Oesophageal cancer

Men, 2018

Incidence per 100,000

Age: 20+

References: Global Cancer Observatory, Cancer incidence rates http://gco.iarc.fr/ (last accessed 30th June 2020)

Definitions: Estimated age-standardized incidence rates (World) in 2018, oesophagus, adults ages 20+. ASR (World) per 100,000
Women, 2018


Definitions: Estimated age-standardized incidence rates (World) in 2018, oesophagus, adults ages 20+. ASR (World) per 100,000
Breast cancer

Women, 2018


Definitions: Estimated age-standardized incidence rates (World) in 2018, breast, females, ages 20+. ASR (World) per 100,000
Colorectal cancer

Men, 2018


Definitions: Estimated age-standardized incidence rates (World) in 2018, colorectum, adults, ages 20+. ASR (World) per 100,000
### Women, 2018

**Age:** 20+

**References:**

**Definitions:**
Estimated age-standardized incidence rates (World) in 2018, colorectum, adults, ages 20+. ASR (World) per 100,000
Pancreatic cancer

Men, 2018

Age: 20+


Definitions: Estimated age-standardized incidence rates (World) in 2018, pancreas, adults, ages 20+. ASR (World) per 100,000
Women, 2018

Age: 20+


Definitions: Estimated age-standardized incidence rates (World) in 2018, pancreas, adults, ages 20+. ASR (World) per 100,000
Gallbladder cancer

Men, 2018

Age: 20+

References: Global Cancer Observatory, Cancer incidence rates [http://gco.iarc.fr/] (last accessed 30th June 2020)

Definitions: Estimated age-standardized incidence rates (World) in 2018, gallbladder, adults, ages 20+. ASR (World) per 100,000
Women, 2018

Age: 20+


Definitions: Estimated age-standardized incidence rates (World) in 2018, gallbladder, adults, ages 20+. ASR (World) per 100,000
Kidney cancer

Men, 2018


Definitions: Estimated age-standardized incidence rates (World) in 2018, kidney, adults, ages 20+. ASR (World) per 100,000
Women, 2018

Age: 20+


Definitions: Estimated age-standardized incidence rates (World) in 2018, kidney, adults, ages 20+. ASR (World) per 100,000
Cancer of the uterus

Women, 2018

References: Global Cancer Observatory, Cancer incidence rates [http://gco.iarc.fr/] (last accessed 30th June 2020)

Definitions: Estimated age-standardized incidence rates (World) in 2018, cervix uteri, females, ages 20+. ASR (World) per 100,000
Raised blood pressure

Adults, 2015

References:
Global Health Observatory data repository, World Health Organisation,
http://apps.who.int/gho/data/node.main.A875?lang=en

Definitions:
Age Standardised estimated % Raised blood pressure 2015 (SBP>=140 OR DBP>=90).
Men, 2015

References:
Global Health Observatory data repository, World Health Organisation,
http://apps.who.int/gho/data/node.main.A875?lang=en

Definitions:
Age Standardised estimated % Raised blood pressure 2015 (SBP>=140 OR DBP>=90).
Women, 2015


Definitions: Age Standardised estimated % Raised blood pressure 2015 (SBP>=140 OR DBP>=90).
Raised cholesterol

Adults, 2008

References:
Global Health Observatory data repository, World Health Organisation,
http://apps.who.int/gho/data/node.main.A885

Definitions:
% Raised total cholesterol (>= 5.0 mmol/L) (age-standardized estimate).
Men, 2008

References:
Global Health Observatory data repository, World Health Organisation,
http://apps.who.int/gho/data/node.main.A885

Definitions:
% Raised total cholesterol (≥ 5.0 mmol/L) (age-standardized estimate).

Definitions: % Raised total cholesterol (≥ 5.0 mmol/L) (age-standardized estimate).
Raised fasting blood glucose

Men, 2014-2019


Definitions: Age Standardised % raised fasting blood glucose (>= 7.0 mmol/L or on medication).
Women, 2014-2019


Definitions: Age Standardised % raised fasting blood glucose (>= 7.0 mmol/L or on medication).
Diabetes prevalence

Adults, 2017


Definitions: Diabetes age-adjusted comparative prevalence (%).
Health systems

Economic classification: Upper Middle Income

Health systems summary

The Mexican Health System is complex; made up of public healthcare and employer-funded insurance schemes as well as private health insurance schemes that involve out of pocket payment. Employees of the state are provided for by the Institute for Social Security and Services, while non-state employees are provided for through the Mexican Institute of Social Security. Employees of the navy, armed forces and oil industry all have their own arrangements. For those that are unemployed or are in poverty, healthcare is provided for through Sistema de Protección Social en Salud (Seguro Popular). Serguro Popular was introduced as a step towards ensuring Universal Health Coverage in Mexico and currently covers approximately 42.2% of the population. Those covered receive selected healthcare treatments free at the point of service. The poorest Mexicans do not have to contribute to the scheme while those with an income pay a small fee based on earnings. Still, however, out of pocket payments remain high at 41% of total health expenditure.

One of the main drawbacks to the Mexican health system is the lack of continuity of care. If you are in one system you usually cannot use the facilities of another (with some exceptions). This means that if employment status changes during treatment individuals often must switch facilities.

Indicators

<table>
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<th>Question</th>
<th>Status</th>
</tr>
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<tr>
<td>Where is the country’s government in the journey towards defining ‘Obesity as a disease’?</td>
<td>Some progress</td>
</tr>
<tr>
<td>Where is the country’s healthcare provider in the journey towards defining ‘Obesity as a disease’?</td>
<td>Some progress</td>
</tr>
<tr>
<td>In practice, how is obesity treatment largely funded?</td>
<td>Out of pocket</td>
</tr>
<tr>
<td>Is there specialist training available dedicated to the training of health professionals to prevent, diagnose, treat and manage obesity?</td>
<td>No</td>
</tr>
<tr>
<td>Have any taxes or subsidies been put in place to protect/assist/inform the population around obesity?</td>
<td>Yes</td>
</tr>
<tr>
<td>Are there adequate numbers of trained health professionals in specialties relevant to obesity in urban areas?</td>
<td>Partial</td>
</tr>
<tr>
<td>Are there adequate numbers of trained health professionals in specialties relevant to obesity in rural areas?</td>
<td>No</td>
</tr>
<tr>
<td>Are there any obesity-specific recommendations or guidelines published for adults?</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Are there any obesity-specific recommendations or guidelines published for children?

Partial

**Perceived barriers to treatment**

- Lack of political will, interest, and action
- Food cost and availability
- Lack of training for healthcare professionals
- Poor health literacy and behaviour
- Obesity not recognised as a disease

**Summary of stakeholder feedback**

In Mexico, obesity is said to be increasingly prioritised by the government, with slow shifts towards recognising it as a disease. This is partly due to the high and increasingly prevalence and the impact this is having on the health system. Many healthcare professionals are said to consider obesity only as a risk factor for other diseases, with many considering it to be a problem of the individual. As a result, people living with obesity are routinely stigmatised within the health system.

Stakeholders reported that the typical cut off used for initiating treatment is BMI ≥ 30 Kg/m² but government funding tends to not be given for obesity itself but rather obesity-related co-morbidities. Treatment within the public system is therefore limited, with long waiting times between appointments, a lack of personalised treatment and low success rates. In the private system on the other hand, there tends to be more successful weight loss and more treatment options (e.g. psychological and behavioural treatments). Unfortunately, this treatment in the private system is usually paid for out of pocket because of the lack of insurance coverage for obesity treatment. Obesity treatment in Mexico is therefore inaccessible for many and only those that have comorbidities enter the system in the first place.

It was noted that although Mexico has clinical guidelines and a national obesity strategy, both are not fully implemented. Stakeholders felt that the obesity strategy does not go far enough and so despite the prevention campaigns and the introduction of taxes, obesity rates are still rising, particularly in rural areas and among children.

Stakeholders also agreed that appropriate specialist obesity training is limited in Mexico. As a result, there are limited obesity specialists in urban areas, with virtually none in rural areas. This situation is worsened by private hospitals promoting ‘bariatric tourism’ that results in qualified bariatric surgeons focussing on treating overseas visitors.

Innovative technologies to connect rural populations to primary health care centres have been trialed in Mexico but success has been limited by lack of internet access in these areas. Other applications are said to have limited uptake.
Based on interviews/survey returns from 20 stakeholders

Last updated: June 2020