

La Carga de la Enfermedad, las Lesiones y los Factores de Riesgo en México 1990- 2013: resultados a nivel Nacional y Estatal

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Economía y Salud, 1994



Definición

- El Concepto de “*La Carga*” proviene de una traducción de “*The Burden*” que quiere decir, “*carga, lastre, peso*”
- Entonces se trata de la carga o el peso que las enfermedades, las lesiones y los factores de riesgo le generan al Sistema de Salud.
- Es el lastre con el que se tiene que mover el sistema....
- El estudio de la Carga Mundial de la Enfermedad, es un esfuerzo científico sistemático para cuantificar la magnitud comparativa de las pérdidas de salud por enfermedades, lesiones y factores de riesgo; por edad, sexo, zonas geográficas y puntos específicos en el tiempo

Midiendo la Carga

- Para medir la carga o el peso de la enfermedad se usan indicadores compuestos
- En lugar de contar las muertes y los casos de enfermedad o discapacidad, QUE NO SE PUEDEN AGREGAR, se calcula el **tiempo** perdido por muerte prematura y el **tiempo** vivido con discapacidad

$$\begin{array}{ccc} \text{AVISA} & = & \text{APMP} & + & \text{AVD} \\ \downarrow & & \downarrow & & \downarrow \\ \text{Pérdida de la salud} & & \text{Pérdida de la salud debida a} & & \text{Pérdida de la salud debida a vivir} \\ & & \text{muerte prematura} & & \text{con una discapacidad} \end{array}$$

Fuentes de datos para el GBD por estados

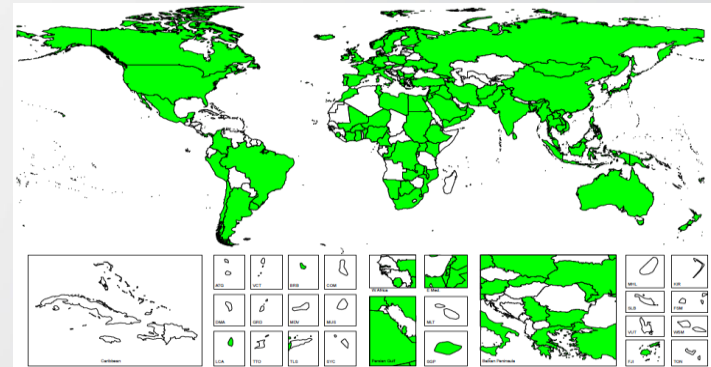
- Para correr los modelos de causas de muerte y casos, se construyó una matriz de covariables de 1990 a 2013. Se requerían 363 y se completó 80% a nivel estatal
- Para calcular los Años perdidos por Muerte Prematura se emplearon las bases de datos de defunciones del INEGI de 1980 a 2013
- Para calcular los resultados no letales se emplearon resultados de las encuestas de salud (1987 a 2012), registros epidemiológicos y estudios epidemiológicos especiales (publicaciones), así como los egresos hospitalarios
- Para calcular la carga atribuible a los factores de riesgo se generaron variables a nivel estatal, regional o nacional para 58 de los 79 factores de riesgo estudiados

¿Quiénes hicieron los cálculos del estudio de México?

- Los datos que se usaron para los cálculos fueron proporcionados por un grupo de investigadores mexicanos
- Los modelos para generar resultados se realizaron en Seattle (IHME)
- Los resultados publicados derivan de la revisión de los colaboradores del mundo, incluyendo los mexicanos

62 investigadores de los Institutos Nacionales de Salud
INSP 47; INNSZ 2; INPs 2; INGer 2, Censida 2

En Seattle, en la UW se ubican más de 20 investigadores y 50 analistas



Más de mil colaboradores en más de 100 países



Global, regional, and national cause-specific mortality for 24 causes: a systematic analysis for the GBD 2013

GBD 2013 Mortality and Causes of Death Collaborators*

Summary

Background Up-to-date evidence on levels and trends for essential for the formation of global, regional, and national 2013 (GBD 2013) we estimated yearly deaths for 188 countries whether there is epidemiological convergence across countries

Methods We estimated age-sex-specific all-cause mortality using accuracy applied to an updated database of vital registration deaths as in the GBD 2010. Key improvements included the use of an updated verbal autopsy literature review, two new and detailed Turkey, and Russia. We improved statistical models for geospatial strategies across the 240 causes; cause of death ensemble models for sufficient information. Trends for Alzheimer's disease as prevalence studies. For pathogen-specific causes of diarrhoeal approach. We computed two measures of convergence (inequality) all pairs of countries (Gini coefficient) and the average absolute we used multiple decrement life-tables to decompose probabilities 15 years to exact age 50 years, and from exact age 50 years to exact age 75 years. For all quantities reported, we computed 95% uncertainty intervals within each age-sex-country-year group to sum to all-cause mortality

Findings Global life expectancy for both sexes increased (UI 71.0–71.9) in 2013, while the number of deaths increased (UI 53.6–56.3) over the same interval. Global progress in differences between countries decreased but relative differences remained large. For men aged 20–49 years and 65 years at decomposition of global and regional life expectancy show rates for cardiovascular diseases and cancers in high-income lower respiratory infections, and neonatal causes in low-income sub-Saharan Africa. For most communicable causes of death whereas for most non-communicable causes, demographic standardised death rates. Global deaths from injury increased 2013; but age-standardised rates declined over the same period in 2013, age-standardised death rates increased between fibrillation and flutter, drug use disorders, diabetes, chronic lower respiratory infections, neonatal causes, and malaria at 5 years. The most important pathogens are rotavirus for diarrhoeal Country-specific probabilities of death over three phases of life

Interpretation For most countries, the general pattern of mortality with a progressive shift towards a larger share of the total deaths from injuries. Assessing epidemiological convergence across countries of inequality is used. Nevertheless, age-standardised death rates for the potential for reversals in some countries. Important findings for some countries; for example, no national data for India

Funding Bill & Melinda Gates Foundation.

Global, regional, and national years lived with disability and injuries in 188 countries: a systematic analysis for the GBD 2013

Global Burden of Disease Study 2013 Collaborators*

Summary

Background Up-to-date evidence on levels and trends for disability (YLDs) is an essential for the formation of global, regional, and national 2013 (GBD 2013) 188 countries between 1990 and 2013

Methods Estimates were calculated with some important refinements additions to the analysis. Key improvements included the use of detailed injury code severity splits for various causes, and cause and impairment during third cause were used and documented to simulation provides estimates for Disability weights were updated with

Findings Disease and injury were rose substantially with age and in infectious diseases and short-term disease episodes in 2013, with the incident cases in 2013. Conversely with prevalence estimates for asymptomatic respectively. The distribution of the relation between age and disease 764.8 million in 2013 due to population 114.87 per 1000 people to 110.31 pain and major depressive disorders major cause groups, indicated the disorders. neurological disorders increasing YLDs in sub-Saharan globally from 21.1% in 1990 to 31

Interpretation Ageing of the world sequelae of diseases and injuries. dimensions of disease and injury fatal outcomes as the dominant results can guide future health in of variation across countries.

Funding Bill & Melinda Gates Foundation.

Introduction

The Global Burden of Disease Study is the first of a series of yearly updates that began with estimates for 2010. The 2013 systematically quantified prevalence

Global, regional, and national burden of 79 behavioural, metabolic, and cardiovascular risks or clusters of risks in 188 countries, 1990–2013: a systematic analysis for the GBD 2013

GBD 2013 Risk Factors Collaborators*

Summary

Background The Global Burden of Disease Study 2013 (GBD 2013) annual updates of the GBD. Risk factors emerging threats to population health to update the comparative risk assessment counterfactual risk distribution.

Methods Attributable deaths, years of life lost, and disability-adjusted life years (DALYs) have been estimated for 79 risks or clusters of risks. Explicit evidence criteria were assessed risk exposure, relative risks, and the hierarchy with blocks of behavioural, diet, and physical activity. The next level in the hierarchy detail provided at levels 3 and 4 of the handwashing practices, occupational sex, and low glomerular filtration rate regression method, DisMod-MR 2.0, meta-regressions of published cohort combined took into account evidence other risks such as high systolic blood

Findings All risks combined account (40.1–43.0) of DALYs. Risks quantified to a low of 0% for neonatal disorders 2013, six risks or clusters of risks caused 241.4 million DALYs, high child and maternal malnutrition for deaths and 143.5 million DALYs, air 4.4 million deaths and 134.0 million DALYs in sub-Saharan Africa, the leading risk for stroke, tuberculosis, and handwashing. In western countries, and in many other high-income countries as the leading risk in most blood pressure or tobacco use are the Middle East, Europe, and Asia. For 1990–2013, South Africa.

Interpretation Behavioural, environmental, and metabolic risks are the leading contributors to the global burden of high BMI has factors, behavioural and social science prevention and primary care policy options

Funding Bill & Melinda Gates Foundation.

Global, regional, and national disability-adjusted life years (DALYs) for 306 diseases and injuries and healthy life expectancy (HALE) for 188 countries, 1990–2013: quantifying the epidemiological transition

GBD 2013 DALYs and HALE Collaborators*

Summary

Background The Global Burden of Disease Study 2013 (GBD 2013) aims to bring together all available epidemiological data using a coherent measurement framework, standardised estimation methods, and transparent data sources to enable comparisons of health loss over time and across causes, age-sex groups, and countries. The GBD can be used to generate summary measures such as disability-adjusted life-years (DALYs) and healthy life expectancy (HALE) that make possible comparative assessments of broad epidemiological patterns across countries and time. These summary measures can also be used to quantify the component of variation in epidemiology that is related to sociodemographic development.

Methods We used the published GBD 2013 data for age-specific mortality, years of life lost due to premature mortality (YLLs), and years lived with disability (YLDs) to calculate DALYs and HALE for 1990, 1995, 2000, 2005, 2010, and 2013 for 188 countries. We calculated HALE using the Sullivan method; 95% uncertainty intervals (UIs) represent uncertainty in age-specific death rates and YLDs per person for each country, age, sex, and year. We estimated DALYs for 306 causes for each country as the sum of YLLs and YLDs; 95% UIs represent uncertainty in YLL and YLD rates. We quantified patterns of the epidemiological transition with a composite indicator of sociodemographic status, which we constructed from income per person, average years of schooling after age 15 years, and the total fertility rate and mean age of the population. We applied hierarchical regression to DALY rates by cause across countries to decompose variance related to the sociodemographic status variable, country, and time.

Findings Worldwide, from 1990 to 2013, life expectancy at birth rose by 6.2 years (95% UI 5.6–6.6), from 65.3 years (65.0–65.6) in 1990 to 71.5 years (71.0–71.9) in 2013. HALE at birth rose by 5.4 years (4.9–5.8), from 56.9 years (54.5–59.1) to 62.3 years (59.7–64.8), total DALYs fell by 3.6% (0.3–7.4), and age-standardised DALY rates per 100 000 people fell by 26.7% (24.6–29.1). For communicable, maternal, neonatal, and nutritional disorders, global DALY numbers, crude rates, and age-standardised rates have all declined between 1990 and 2013, whereas for non-communicable diseases, global DALYs have been increasing. DALY rates have remained nearly constant, and age-standardised DALY rates declined during the same period. From 2005 to 2013, the number of DALYs increased for most specific non-communicable diseases, including cardiovascular diseases and neoplasms, in addition to dengue, food-borne trematodes, and leishmaniasis; DALYs decreased for nearly all other causes. By 2013, the five leading causes of DALYs were ischaemic heart disease, lower respiratory infections, cerebrovascular disease, low back and neck pain, and road injuries. Sociodemographic status explained more than 50% of the variance between countries and over time for diarrhoea, lower respiratory infections, and other common infectious diseases; maternal disorders; neonatal disorders; nutritional deficiencies; other communicable, maternal, neonatal, and nutritional diseases; musculoskeletal disorders; and other non-communicable diseases. However, sociodemographic status explained less than 10% of the variance in DALY rates for cardiovascular diseases; chronic respiratory diseases; cirrhosis; diabetes, urogenital, blood, and endocrine diseases; unintentional injuries; and self-harm and interpersonal violence. Predictably, increased sociodemographic status was associated with a shift in burden from YLLs to YLDs, driven by declines in YLLs and increases in YLDs from musculoskeletal disorders, neurological disorders, and mental and substance use disorders. In most country-specific estimates, the increase in life expectancy was greater than that in HALE. Leading causes of DALYs are highly variable across countries.

Interpretation Global health is improving. Population growth and ageing have driven up numbers of DALYs, but crude rates have remained relatively constant, showing that progress in health does not mean fewer demands on health systems. The notion of an epidemiological transition—in which increasing sociodemographic status brings structured change in disease burden—is useful, but there is tremendous variation in burden of disease that is not associated with sociodemographic status. This further underscores the need for country-specific assessments of DALYs and HALE to appropriately inform health policy decisions and attendant actions.

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*Collaborators listed at the end of the Article

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<http://www.healthdata.org/results/data-visualizations>

The screenshot shows the IHME (Institute for Health Metrics and Evaluation) website's 'Data Visualizations' page. At the top, there is a navigation menu with links for Home, Results (highlighted), News & Events, Projects, Get Involved, and About. The main heading is 'Data Visualizations'. On the left, a sidebar lists various content types: RESULTS, Data Visualizations (underlined), Country Profiles, Policy Reports, Research Articles, Infographics, Presentations, US County Profiles, Topics, and Data & Tools. The main content area features search filters for 'Topics' (set to '- Any -') and 'Date published' (set to '- Year -'), with an 'Advanced' search option and 'Apply' and 'Reset' buttons. Three featured visualizations are displayed: 1. 'China subnational MDG 4' (October 25, 2015), a choropleth map of China showing under-5 mortality rates by province. 2. 'HIV Worldwide 1990-2013 Visualization' (October 20, 2015), a line chart showing trends in HIV/AIDS death, incidence, and prevalence. 3. 'GBD Compare' (September 15, 2015), a treemap visualization for analyzing health levels and trends from 1990 to 2013.

IHME
Institute for Health Metrics and Evaluation

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OCTOBER 25, 2015
China subnational MDG 4
Data Visualization
[Learn more](#)

See how China is progressing toward Millennium Development Goal 4 (MDG 4) at the subnational level by exploring and comparing province and county trends for under-5 mortality rates in China between 1996 and 2012 (counties) or 2013 (provinces). Chinese and English language options are available in this visualization tool.

OCTOBER 20, 2015
HIV Worldwide 1990-2013 Visualization
Data Visualization
[Learn more](#)

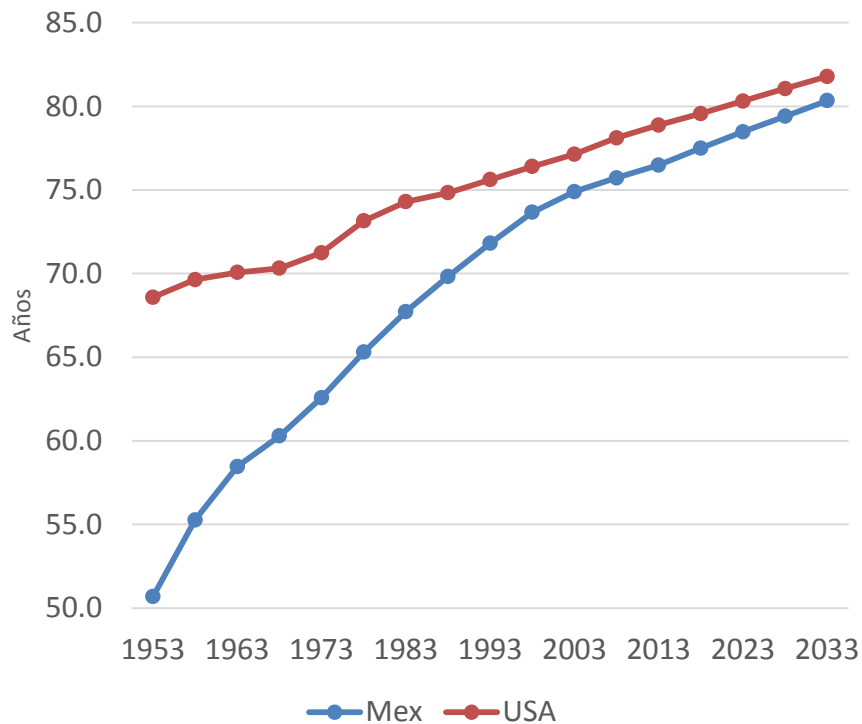
Created for The Journal of the American Medical Association, this interactive data visualization tool shows estimated trends in HIV/AIDS death, incidence, and prevalence worldwide and by country for the years 1990 to 2013.

SEPTEMBER 15, 2015
GBD Compare
Data Visualization
[Learn more](#)

Analyze the world's health levels and trends from 1990 to 2013 in this revamped interactive tool. Use treemaps, maps, arrow diagrams, and other charts to compare causes and risks within a country, compare countries with regions or the world, and explore patterns and trends by country, age, and gender. Drill from a global view into specific details. Watch how disease patterns have changed over time. See which causes of death and disability are having more impact and which are waning.

Importante Progreso en Salud

Esperanza de Vida al Nacer en ambos sexos



Source: UN. World Population Prospects: The 2015 Revision.

The Lancet Commissions

GLOBAL HEALTH 2035

THE LANCET



Global health 2035: a world converging within a generation

Dean T Jamison*, Lawrence H Summers*, George Alleyne, Kenneth J Arrow, Seth Berkley, Agnes Binagwaho, Flavia Bustreo, David Evans, Richard G A Ffrench, Julio Frenk, Gargee Ghosh, Sue J Goldie, Yan Guo, Sanjeev Gupta, Richard Horton, Margaret E Kruk, Adel Mahmoud, Linah K Mohohlo, Mthuli Ncube, Ana Pablos-Mendez, K Srinath Reddy, Helen Saxenian, Agnes Scazzat, Karen H Ulltveit-Moe, Gavin Yamey

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This online publication has been corrected. The corrected version first appeared at thelancet.com on Jan 17, 2014.

See Comment pages 1893, 1861, e33, e34, e36, and e38

*Denotes co-first author

See Online for video infographic

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Executive summary

Prompted by the 20th anniversary of the 1993 World Development Report, a Lancet Commission revisited the case for investment in health and developed a new investment framework to achieve dramatic health gains by 2035. Our report has four key messages, each accompanied by opportunities for action by national governments of low-income and middle-income countries and by the international community.

There is an enormous payoff from investing in health

The returns on investing in health are impressive. Reductions in mortality account for about 11% of recent economic growth in low-income and middle-income countries as measured in their national income accounts.

However, although these accounts capture the benefits that result from improved economic productivity, they fail to capture the value of better health in and of itself. This intrinsic value, the value of additional life-years (VLYs), can be inferred from people's willingness to trade off income, pleasure, or convenience for an increase in their life expectancy. A more complete picture of the value of health investments over a time period is given by the growth in a country's "full income"—the income growth measured in national income accounts plus the VLYs gained in that period. Between 2000 and 2011, about 24% of the growth in full income in low-income and middle-income countries resulted from VLYs gained.

This more comprehensive understanding of the economic value of health improvements provides a strong rationale for improved resource allocation across sectors.

Opportunities:

- If planning ministries used full income approaches (assessing VLYs) in guiding their investments, they could increase overall returns by increasing their domestic financing of high-priority health and health-related investments.
- Assessment of VLYs strengthens the case for allocating a higher proportion of official development assistance to development assistance for health.

A "grand convergence" in health is achievable within our lifetimes

A unique characteristic of our generation is that collectively we have the financial and the ever-improving technical capacity to reduce infectious, child, and maternal mortality rates to low levels universally by 2035, to achieve a "grand convergence" in health. With enhanced investments to scale up health technologies and systems, these rates in most low-income and middle-income countries would fall to those presently seen in the best-performing middle-income countries. Achievement of convergence would prevent about 10 million deaths in 2035 across low-income and lower-middle-income countries relative to a scenario of stagnant investments and no improvements in technology. With use of VLYs to estimate the economic benefits, over the period 2015-35 these benefits would exceed costs by a factor of about 9-20, making the investment highly attractive.

Opportunities:

- The expected economic growth of low-income and middle-income countries means that most of the incremental costs of achieving convergence could be covered from domestic sources, although some countries will continue to need external assistance.
- The international community can best support convergence by funding the development and delivery of new health technologies and curbing antibiotic resistance. International funding for health research and development targeted at diseases that disproportionately affect low-income and middle-income countries should be doubled from current amounts (US\$3 billion/year) to \$6 billion per year by 2020. The core functions of global health, especially the provision of global public goods and management of externalities, have been neglected in the last 20 years and should regain prominence.

Fiscal policies are a powerful and underused lever for curbing of non-communicable diseases and injuries

The burden of deaths from non-communicable diseases (NCDs) and injuries in low-income and middle-income

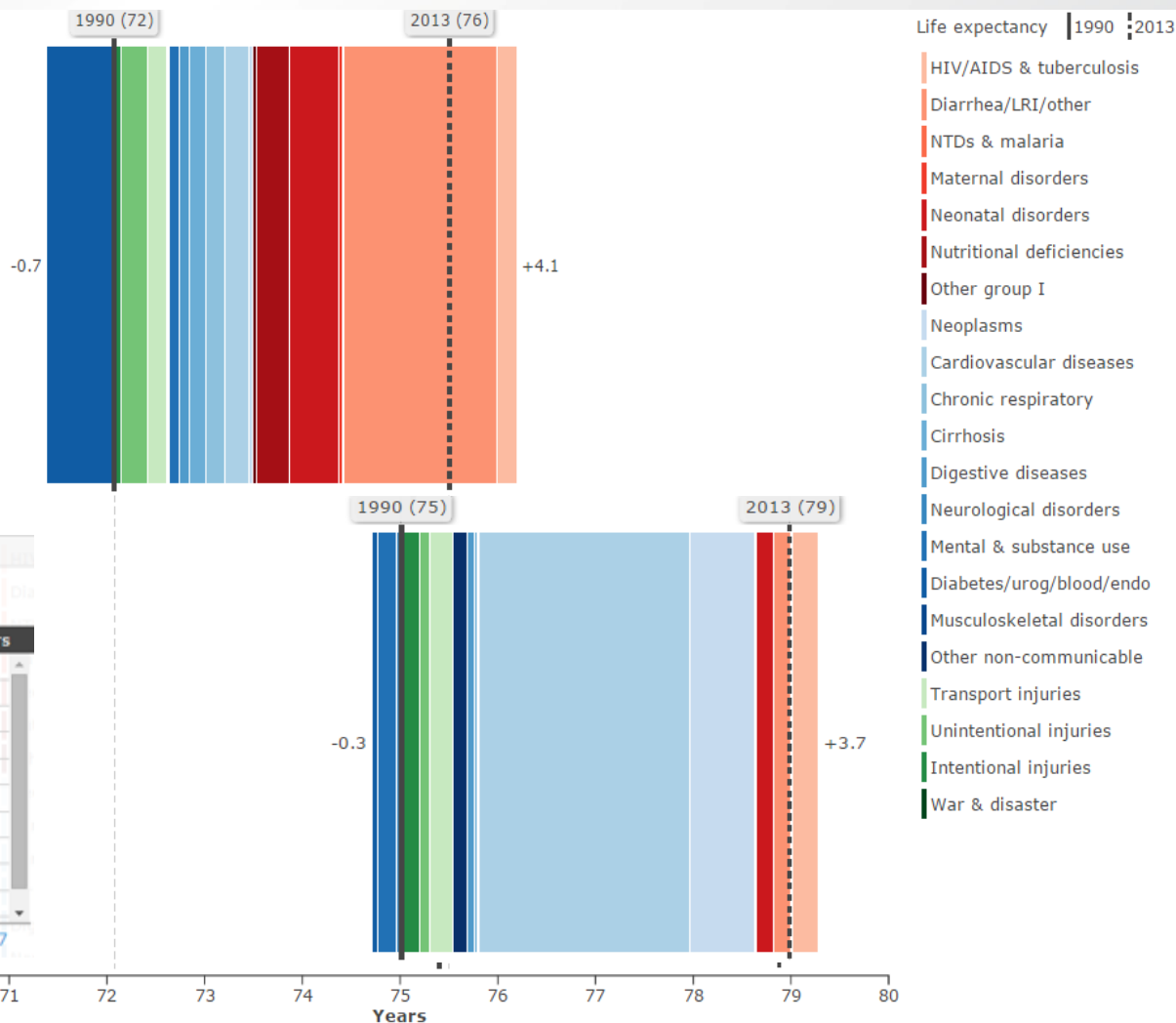
Descomposición de las causas de muerte que modifican la Esperanza de vida al nacer, México y EUA 1990-2013

How causes contributed to change in life expectancy

Mexico			
	1990 72 years	2013 76 years	Change +3.4
Decreased life expectancy			
Diabetes/urog/blood/endo	-0.7		
<i>Values greater than -.05 were omitted</i>			
Total years lost	-0.7		
Increased life expectancy			
Diarrhea/LRI/other		+1.6	
Neonatal disorders		+0.5	
Nutritional deficiencies		+0.3	
Unintentional injuries		+0.3	
Cardiovascular diseases		+0.2	
HIV/AIDS & tuberculosis		+0.2	
Chronic respiratory		+0.2	
Transport injuries		+0.2	
Cirrhosis		+0.2	
Mental & substance use		+0.1	
Total years gained		+4.1	

How causes contributed to change in life expectancy

United States			
	1990 75 years	2013 79 years	Change +3.5
Decreased life expectancy			
Mental & substance use	-0.2		
<i>Values greater than -.05 were omitted</i>			
Total years lost	-0.3		
Increased life expectancy			
Cardiovascular diseases		+1.9	
Neoplasms		+0.6	
HIV/AIDS & tuberculosis		+0.2	
Transport injuries		+0.2	
Diarrhea/LRI/other		+0.2	
Intentional injuries		+0.2	
Neonatal disorders		+0.2	
Other non-communicable		+0.1	
Unintentional injuries		+0.1	
Digestive diseases		+0.1	
Total years gained		+3.7	

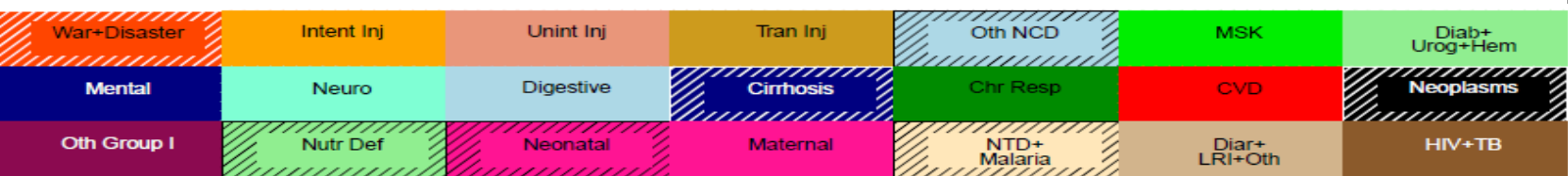
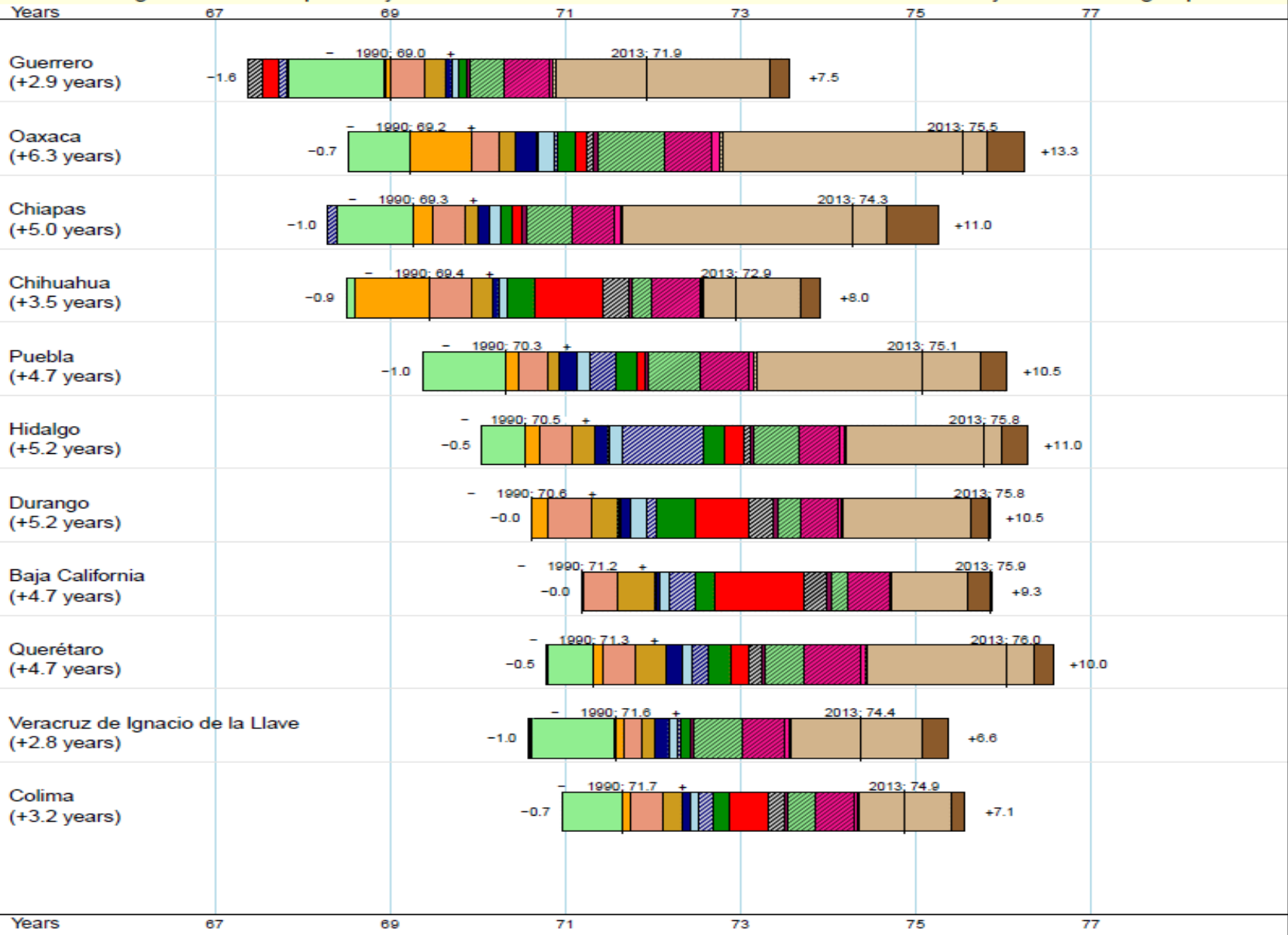


Health Metrics and Evaluation

GBD 2013, released 12/2014

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Change in state life expectancy at birth in Mexico: both sexes combined from 1990–2013 by broad cause group



Determinando prioridades. ¿Qué indicador usar?

Mortalidad (ajs edad)

	%
Cardiopatía Isquémica	14.5
Diabetes mellitus	9.4
Enf. Renal Crónica	9.0
Enf. Cerebrovascular	6.8
Cirrosis	5.9
Enf. Pulmonar obs. Crónica	5.5
Enf. de Alzheimer	4.3
Infec. Respiratoria baja	3.6
Ac. de vehículo de motor	2.9
Homicidios	2.5

Años Perdidos por Muerte Prematura APMP

	%
Cardiopatía Isquémica	9.7
Enf. Renal Crónica	8.1
Diabetes mellitus	7.6
Cirrosis	6.6
Ac. de vehículo de motor	5.2
Homicidios	5.1
Anomalías Congénitas	4.6
Enf. Cerebrovascular	4.5
Infec. Respiratoria baja	3.9
Enf. Pulmonar obs. Crónica	3.2

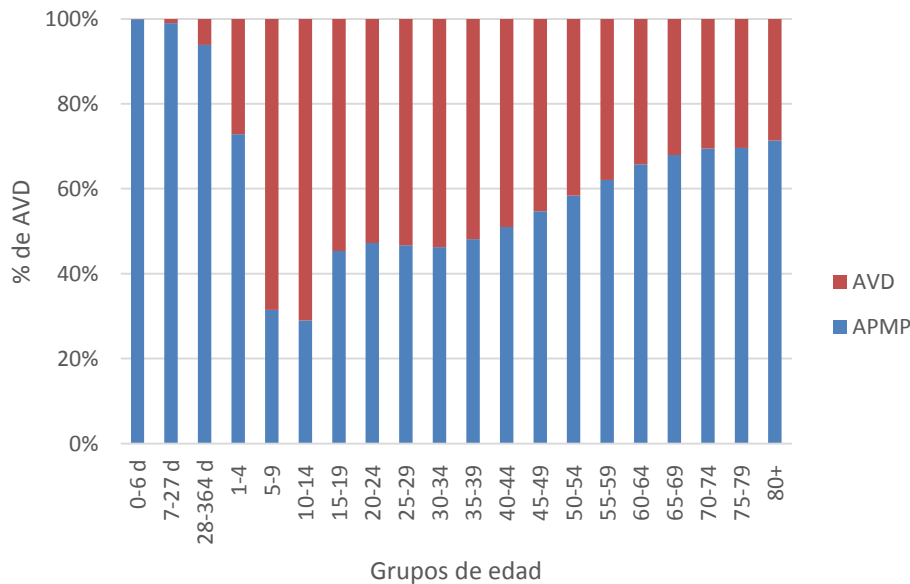
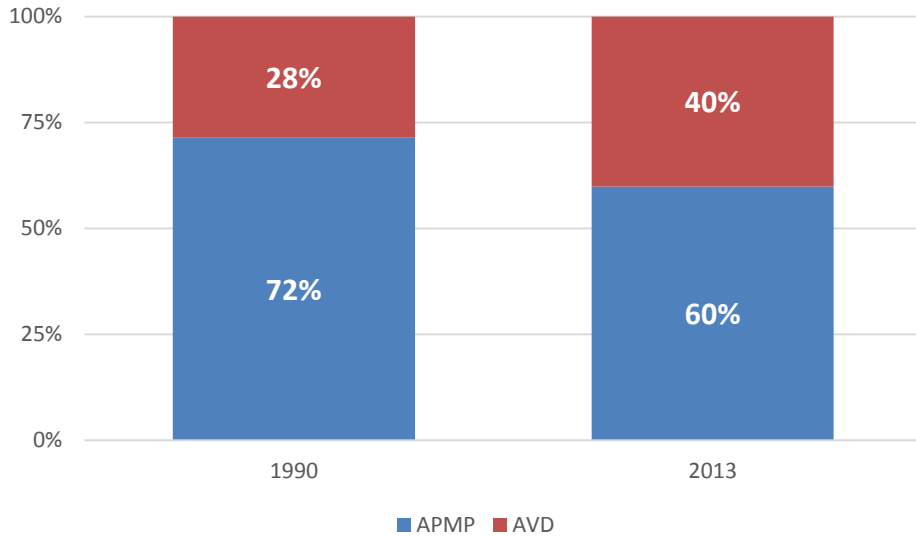
Años Vividos con discapacidad AVD

	%
Depresión	9.8
Lumbalgia	8.3
Diabetes mellitus	6.3
Hipoacusia rel. con la edad	5.1
Otras enf. Musculo esqueléticas	4.6
Ansiedad	3.9
Anemia ferropriiva	3.3
Enf. Pulmonar obs. Crónica	3.3
Dolor de cuello	3.1
Migraña	2.8

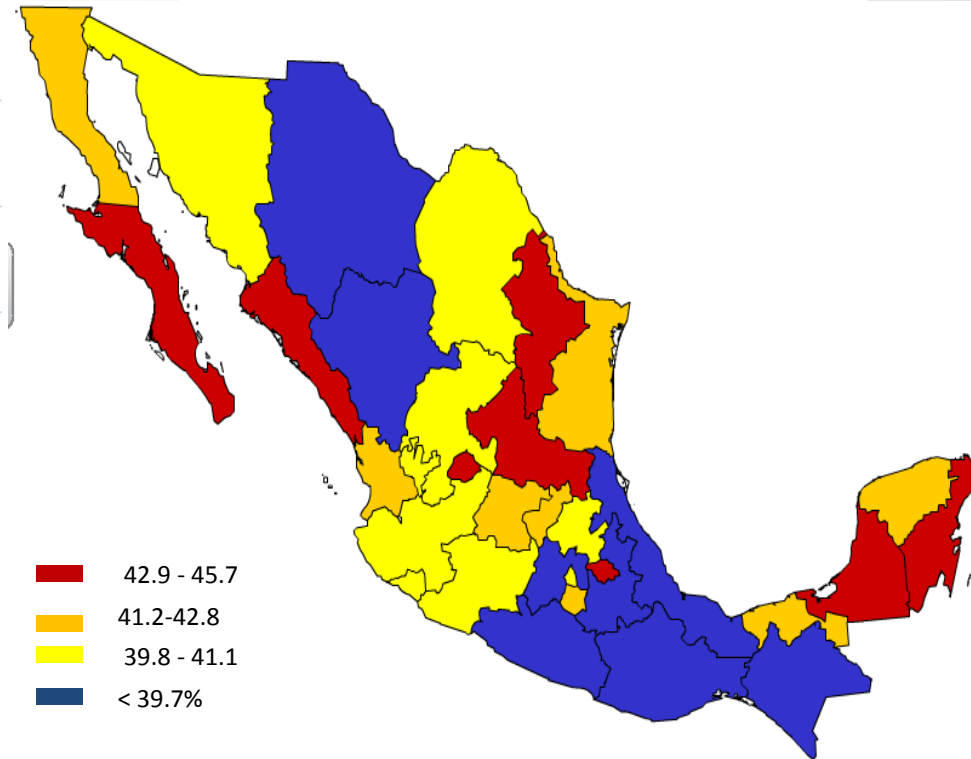
Años de Vida Saludable perdidos AVISA

	%
Diabetes mellitus	7.1
Cardiopatía Isquémica	6.5
Enf. Renal Crónica	5.7
Cirrosis	4.1
Depresión	3.8
Ac. de vehículo de motor	3.4
Anomalías Congénitas	3.4
Enf. Pulmonar obs. Crónica	3.2
Lumbalgia	3.2
Homicidios	3.2

40% de la carga en 2013 esta asociado a Discapacidad

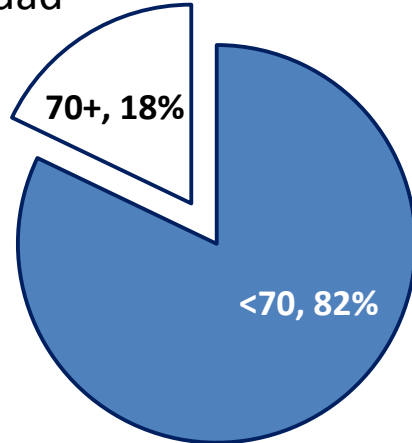


% de AVD en ambos sexos, 2013

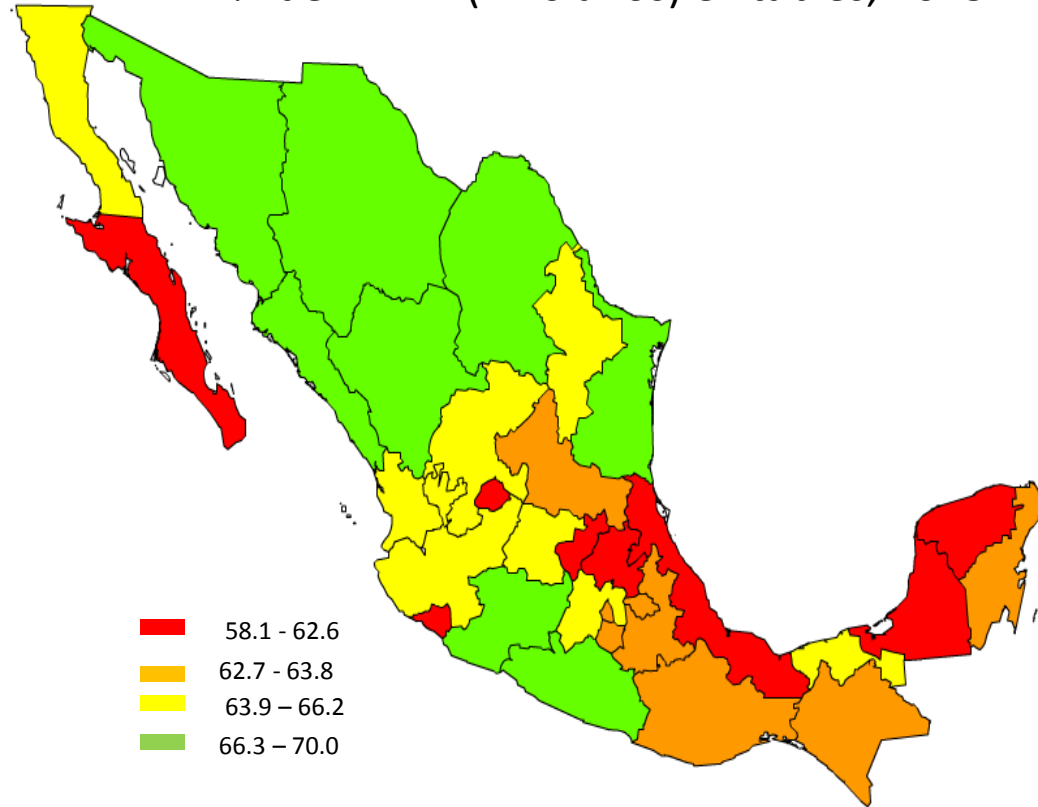


Disminuir 40% la mortalidad prematura para 2030

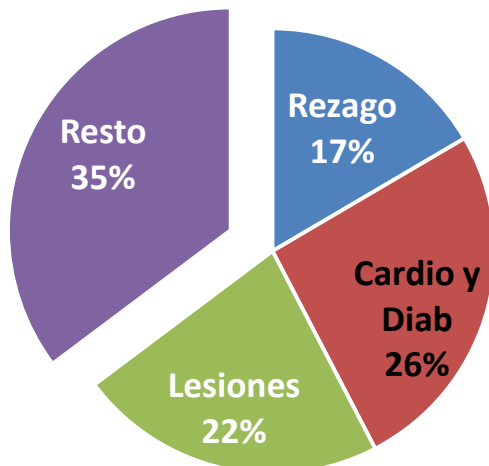
APMP por edad



% de APMP (< 70 años) evitables, 2013



APMP por edad y Causas

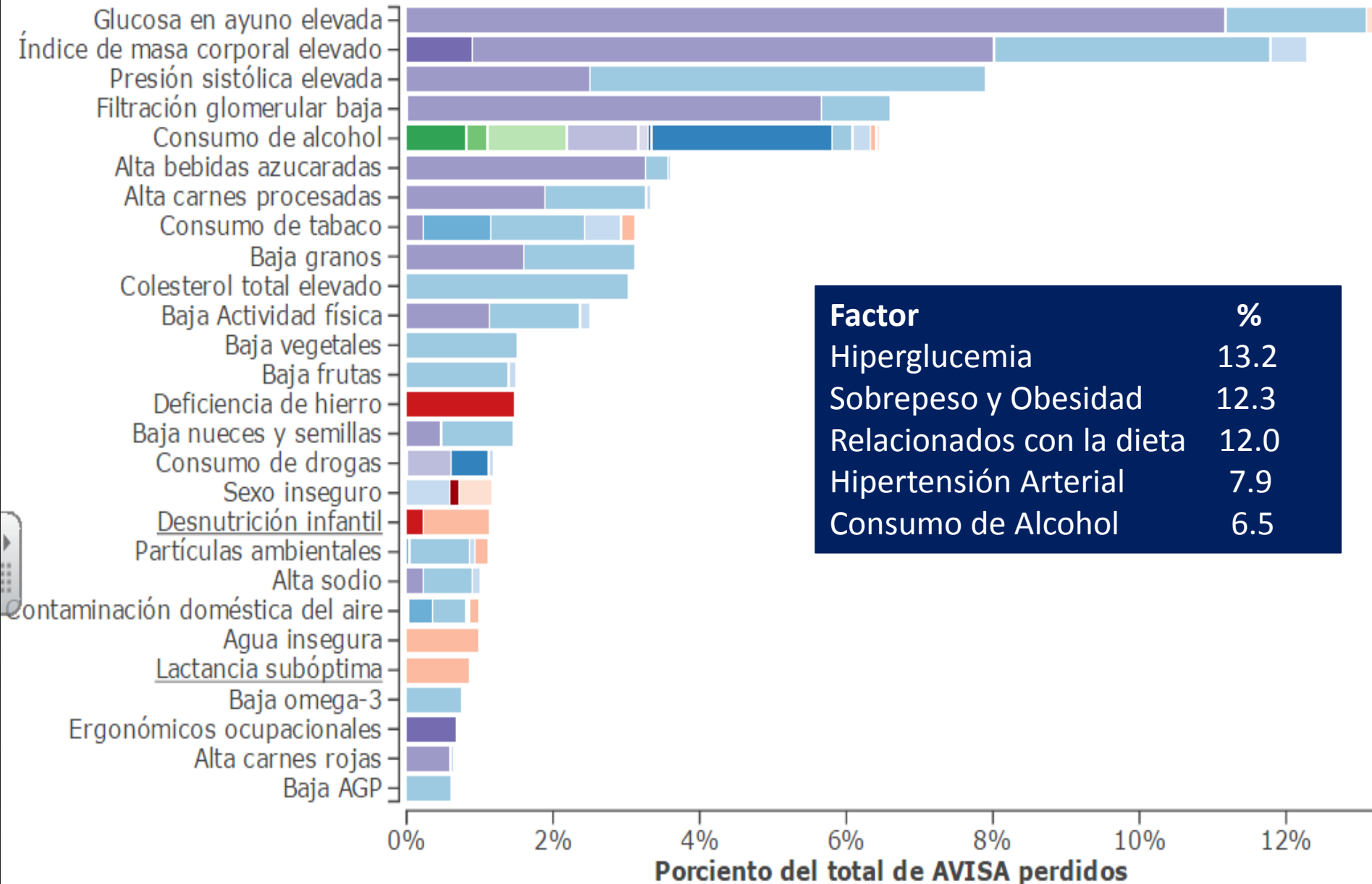


	1	2	3	4	5	6	7	8	9	10
RMEX	DIAB	C ISQ	E.R.C.	CIRROS	DEPRE	A.T	CONGE	EPOC	LUMBA	VIOLEN
AGS	DIAB	E.R.C.	C ISQ	DEPRE	A.T	EPOC	CONGE	LUMBA	CIRROS	E.R.C:
BC	C ISQ	DIAB	E.R.C.	DEPRE	LUMBA	VIOLEN	CIRROS	CONGE	E.C.V.	A.T
BCS	C ISQ	DIAB	E.R.C.	A.T	DEPRE	LUMBA	CONGE	EPOC	CIRROS	E.C.V.
CAM	DIAB	C ISQ	CIRROS	E.R.C.	DEPRE	LUMBA	A.T	CONGE	EPOC	E.C.V.
COAH	C ISQ	DIAB	E.R.C.	DEPRE	LUMBA	A.T	VIOLEN	E.C.V.	CONGE	EPOC
COL	DIAB	C ISQ	E.R.C.	CIRROS	A.T	DEPRE	LUMBA	VIOLEN	EPOC	CONGE
CHIS	DIAB	C ISQ	E.R.C.	CIRROS	DEPRE	LUMBA	I.R.B.	EPOC	E.C.V.	CONGE
CHIH	VIOLEN	C ISQ	DIAB	E.R.C.	A.T	LUMBA	DEPRE	EPOC	CIRROS	E.C.V.
DF	DIAB	C ISQ	E.R.C.	DEPRE	CIRROS	LUMBA	CONGE	EPOC	I.R.B.	E.C.V.
DGO	C ISQ	DIAB	VIOLEN	E.R.C.	CONGE	DEPRE	A.T	LUMBA	EPOC	PREMAT
GTO	DIAB	E.R.C.	C ISQ	A.T	DEPRE	CIRROS	LUMBA	EPOC	CONGE	E.C.V.
GRO	VIOLEN	DIAB	C ISQ	E.R.C.	CIRROS	CONGE	E.C.V.	A.T	LUMBA	DEPRE
HGO	DIAB	C ISQ	E.R.C.	CIRROS	DEPRE	LUMBA	A.T	CONGE	EPOC	E.C.V.
JAL	DIAB	C ISQ	E.R.C.	A.T	CIRROS	DEPRE	EPOC	CONGE	LUMBA	E.C.V.
MEX	DIAB	E.R.C.	C ISQ	CIRROS	I.R.B.	CONGE	EPOC	VIOLEN	DEPRE	A.T
MICH	DIAB	C ISQ	E.R.C.	A.T	DEPRE	VIOLEN	CIRROS	EPOC	LUMBA	CONGE
MOR	DIAB	E.R.C.	C ISQ	LUMBA	CIRROS	DEPRE	VIOLEN	EPOC	CONGE	A.T
NAY	DIAB	C ISQ	E.R.C.	A.T	DEPRE	VIOLEN	CONGE	LUMBA	EPOC	CIRROS
NL	C ISQ	DIAB	E.R.C.	DEPRE	LUMBA	CONGE	VIOLEN	A.T	E.C.V.	EPOC
OAX	DIAB	E.R.C.	CIRROS	C ISQ	DEPRE	VIOLEN	CONGE	LUMBA	E.C.V.	EPOC
PUE	DIAB	E.R.C.	CIRROS	C ISQ	DEPRE	CONGE	LUMBA	A.T	EPOC	I.R.B.
QRO	DIAB	C ISQ	CIRROS	E.R.C.	A.T	DEPRE	LUMBA	CONGE	EPOC	E.C.V.
QROO	DIAB	C ISQ	CIRROS	E.R.C.	DEPRE	LUMBA	A.T	EPOC	CONGE	E.C.V.
SLP	DIAB	C ISQ	E.R.C.	DEPRE	CONGE	LUMBA	A.T	EPOC	CIRROS	E.C.V.
SIN	C ISQ	DIAB	VIOLEN	DEPRE	A.T	E.R.C.	LUMBA	EPOC	CONGE	E.C.V.
SON	C ISQ	DIAB	A.T	E.R.C.	DEPRE	LUMBA	EPOC	CONGE	VIOLEN	E.C.V.
TAB	DIAB	E.R.C.	C ISQ	A.T	DEPRE	LUMBA	CONGE	EPOC	CIRROS	E.C.V.
TAM	C ISQ	DIAB	E.R.C.	VIOLEN	DEPRE	A.T	LUMBA	CONGE	EPOC	E.C.V.
TLAX	DIAB	E.R.C.	CIRROS	DEPRE	C ISQ	LUMBA	A.T	CONGE	EPOC	E.C.V.
VER	DIAB	C ISQ	E.R.C.	CIRROS	DEPRE	CONGE	E.C.V.	LUMBA	EPOC	A.T
YUC	C ISQ	DIAB	CIRROS	E.R.C.	DEPRE	A.T	E.C.V.	CONGE	EPOC	I.R.B.
ZAC	DIAB	C ISQ	A.T	E.R.C.	DEPRE	EPOC	LUMBA	E.C.V.	CONGE	VIOLEN

Principales causas de AVISA perdidos ambos sexos (edad ajses.) 2013

DIAB	Diabetes Mellitus
C ISQ	Cardiopatía Isquémica
E.R.C.	Enf. Renal Crónica
CIRROS	Cirrosis
DEPRE	Depresión
A.T	Accidentes de Transito
CONGE	Anomalías Congénitas
EPOC	Enf. Pulmonar Obs. Crónica
LUMBA	Lumbalgia
VIOLEN	Violencia
E.C.V.	Enf. Cerebrovascular
I.R.B.	Inf. Respiratoria Baja

50% de la carga atribuible se concentra en 5 factores de riesgo, en 2013



Factor	%
Hiperglucemia	13.2
Sobrepeso y Obesidad	12.3
Relacionados con la dieta	12.0
Hipertensión Arterial	7.9
Consumo de Alcohol	6.5

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<http://www.healthdata.org/>

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<http://www.insp.mx/>

