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POLICY NOTE

Health Policy in Mexico

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The Mexican health system: some stylised facts

Mexico has seen dramatic improvements in life expectancy and a steady reduction in infant mortality rates since the 1950s. But it remains below the OECD average for indicators of health status (Table 1). The fertility rate is the second highest in the OECD area after Turkey while its maternal mortality rate is much higher.

Mexico has a comparatively low supply of inputs to the health care sector by OECD standards. For example, Mexico had 1.5 practising doctors per 1000 population in 2002, about half the OECD average, while its equivalent ratio of acute care hospital beds was about a quarter of the OECD average.

Mexico spends considerably less on health than other OECD countries. While total per capita spending on health is near to what might be expected given the level of income, Mexico spends less than other Latin American countries with similar levels of economic development (Figure 1).

The Mexican health-care sector is characterised by a relatively low level of public spending (Figure 2). While the share of public health care spending rose from 40% in 1990 to 45% of total health expenditure in 2002, Mexico remains well below the OECD average of 72%. The United States and Korea have similarly low levels of public funding. Most of private spending in Mexico is financed by out-of-pocket payments, as in Korea but unlike the United States (i.e., there is little private health insurance). The high burden of out-of-pocket expenditure as a share of household consumption --- 4.5% in Mexico versus the 3.0% OECD average --- suggests that the systems falls short of providing adequate insurance coverage, particularly for pharmaceuticals, where a full 90% of spending is financed directly by patients out-of-pocket.

The Mexican health system is marked by fragmentation

The Mexican health care system is, organisationally, quite different from that of most other OECD countries. The public sector is characterised by the presence of several public purchasers that are vertically integrated with providers and serve different parts of the population with little connection between them. In addition, there is a very large, and mostly unregulated, private sector.

Social security institutions, which were first established during the 1940s and 1950s, cover salaried workers in the formal sector[2]. Individuals entitled to coverage by social security institutions (including those paying a contribution and their dependents) are estimated at around half of the population, although estimates vary depending on sources due to the lack of an official register of insurees. The Ministry of Health (MoH) has decentralised most care for those not covered by social insurance to the states that operate their own State Health Service (SHS) systems of public hospitals and clinics. Each institution – whether state or social security – provides health services at all levels of care in their own facilities. The State Health Services are considered as providing care of lesser quality than the social security system in many states, although this partly reflects the fact that the resources per household allocated to the social

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1 This brief draws heavily on OECD (2005), OECD Reviews of Health Care Systems: Mexico, Paris

2 The main social security institutions are the Instituto Mexicano de Seguro Social (IMSS), which covers workers in the private sector, and the Instituto de Seguridad y Servicios Sociales de los Trabajadores (ISSSTE), which covers workers in the public sector.

insurers are roughly two thirds greater than those allocated to the SHS. Doctors and nurses are salaried workers in all institutions. However, a large proportion of doctors is also engaged in private sector practice, where they receive payments on a fee-for-service basis. The private hospital sector provides around one third of all hospital beds in the country. Nearly half of private hospital facilities are concentrated in Mexico City, while richer states have a larger availability of private sector facilities than poorer ones.

The Mexican health system is facing major challenges

Mortality and morbidity patterns in most Mexican states are no longer dominated by communicable diseases and the share of chronic and lifestyle-related illnesses has increased. Nonetheless, a considerable epidemiological backlog remains in states with lower levels of socio-economic development and in rural areas.

Mexico is one of the few OECD countries that have not yet achieved universal or near-universal insurance coverage. The system remains profoundly unequal in terms of access to health care, its financing, and health outcomes. There are large disparities in insurance coverage, public expenditure and health status between the northern and the southern States of the Federation, reflecting differences in levels of economic and social development, education and epidemiological problems. Differences in resource availability and quality also exist across institutions. While those not covered by the social security system can access care at government facilities, significant access barriers remain for those relying entirely on MoH and SHS facilities. A larger proportion of individuals without access to social security protection belongs to the poorest segments of the population and a higher share of households in lower-income quintiles faces catastrophic and poverty-creating health-care expenditures.

The intensity of use of inputs is relatively low in the Mexican health care system. Low intensity of use could signal either low demand from a still young population, or inefficient use of resources. However, considerable variability exists across institutions and across states in the intensity of use, suggesting there is scope for increasing efficiency by raising the performance of the weaker states and institutions. Moreover, the fragmentation of the health care system has likely raised administrative costs by creating duplication of administration. Plausible factors that might explain low efficiency levels include: the coexistence of numerous vertically-integrated insurers and the absence of any separation between purchasers and providers; difficulties in coordination of policies in a decentralised environment; underdeveloped management capacity across decentralised institutions; and weak financial incentives associated with payment systems that do not reward productivity and quality.

While Mexicans appear to be largely satisfied with the care they receive[3], the high share of private spending raises concern about the quality of care and the responsiveness of the public health-care system. Lack of capacity to serve the health care needs in the public sector has led to demand spilling over into the private sector where there is little insurance cover.[4] Budgetary constraints have limited both the quantity and quality of care to the poor, leading to significant implicit rationing throughout the system, for example availability of most drugs in the SHS is extremely poor. There is also wide variability in quality across and within both the public and the private sector.

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3 Secreteria de Salud (2004), *Salud México 2003. Información para la rendición de cuentas.*

4 Although ceilings on the prices of pharmaceuticals paid by consumers in the private market are set through a process administered by the Ministry of the Economy, the methodology used gives the manufacturer significant latitude, with the result that price levels are essentially what would be obtained under a free-market-pricing scheme.

In addressing these challenges, policy makers are confronted with a number of policy constraints. The country is going through a demographic and epidemiological transition which is putting greater pressure on health care systems. The absence of fiscal reform severely limits the scope for increasing government financing of the health care system. Furthermore, the social security sector is facing pressures from increasing pensions for its workers, although recent reforms are expected to attenuate the longer-term effects. Finally the fragmentation of the institutional arrangements with the decentralisation of providers makes it more difficult to build a coherent strategy and create a consensus for change.

An ambitious new reform offers new opportunities

Over the 1990s, the Mexican authorities established a Reform Plan for the Health Service 1995-2000 and put in place several changes aimed at widening access of the uninsured population to health care services. The financing of IMSS was also reformed and the decentralisation of health care services for the uninsured to the States, which had been started in the 1980s, was completed.

Subsequently, the current administration presented the 2001-2006 National Health Programme (Programa Nacional de Salud, 2001-2006, PNS[5]), which stressed equity concerns both with respect to financing and access to health care. The key reform of this ambitious health-sector reform programme is the System of Social Protection in Health. This initiative aims at improving financial protection for those without social security coverage, injecting new resources into the system, and re-balancing the financial transfers from the Federal government to the States. The design of the reform has been supported by and grounded in analysis and available evidence on the performance of the Mexican health system[6].

The new system aims to provide progressively the population outside the social security system with a voluntary health insurance option (so-called "Seguro Popular", Popular Health Insurance). The Popular Health Insurance scheme covers affiliated families with a package of essential interventions and selected catastrophic treatments[7]. The system is financed through a combination of existing and new financial resources. For each affiliated family, the Federal and State governments each pay per family contributions, which are topped up by a small income-tested premium paid by the insurees. The Federal and part of the State contributions represent new money added to the system, which is directed to those States currently receiving fewer resources from federal transfers. By introducing a mechanism that would allocate more resources to poorer states (also those with the largest shares of the population not covered by social security), this is intended to offset gradually the current inequitable federal health allocations to the States. A separate fund is also established to finance public health and community health services, in order to ensure that public health services are not sacrificed during periods of budgetary restraint.

Enrolment into the Popular Health Insurance scheme remains voluntary, although states have an incentive to affiliate as many people as possible as the allocation of new federal resources is contingent on the number of affiliated families. As providers' payments will go where patients are actually treated, health care services can be potentially provided by any provider operating in the Mexican National Health System

5 The National Health Programme establishes the strategies and action plan for the 2001-2006 federal administration.

6 For example, Mexico has implemented the OECD framework "A System of Health Accounts", an international "public good" that supports health policy making by providing detailed data on sources and uses of funds in the health system.

7 At present, this package is estimated to cover more than 50% of the demand for health care.

(which includes social security as well as MoH and SHS providers). The principle of "money follows the patients" is intended to be a first step towards breaking the silos-style link between insurers and providers, although, at least in its initial phase, only State health facilities are likely to operate as providers of services to enrolees of the Popular Health Insurance in most states. With money eventually following the patient, it is also hoped that providers will have encouragement to improve quality and efficiency of provision.

But challenges remain

Despite the well-devised design of the new reform, there remain challenges to its successful implementation:

- The availability of fresh resources to finance the expansion of the system is endangered by the current fiscal constraints facing Mexico. While a real increase of resources was authorised in 2004 and also budgeted for 2005, in the absence of tax reform, it will be difficult in the future to free resources from existing entitlement programmes. Nonetheless, the federal budget for health – both for its own spending and transfers to the states – has increased in recent budgets. This progress needs to continue to ensure that fuller coverage for the uninsured is achieved.

- As the System of Social Protection in Health only covers a well-defined set of basic services and offers limited protection for catastrophic risks, pressures to expand such benefit coverage may arise from the users. The appropriate definition of a standardised packaged may also change as new technology and drugs modify the cost-effectiveness of treatment. In the event, the basic package has been widened in recent months to cover a range of additional catastrophic illnesses.

- While the enrolment process starts with the poorest families, the new insurance system risks creating incentives for providers to give preference in treatment to the enrolee vis-à-vis those not enrolled in the new insurance scheme, especially during the transition period from 2004 to 2010.

- The Seguro Popular covered 30 per cent of families not covered by social security at the end of 2005 and seems to be on track for full coverage by 2010. Expanding enrolment in the Seguro Popular will in part depend upon improvements in the quality of provision and physical access to care in SHS facilities, particularly in poorer States with weaker capacity and in rural areas. Given new demand for public sector services, SHS providers will face the need to increase efficiency. Improving incentives, management and provider efficiency at the state level remains a key policy challenge.

- Current methods of payment of providers provide few incentives for improvements in productivity. Virtually all of the Mexican institutional providers are financed through capped budgets while workers are paid on a salary basis. International experience suggests that some shift to payment on the basis of output would encourage providers to search for higher efficiency.

- In the longer term, the success of the System of Social Protection in Health will hinge upon its ability to break the link between financing and provision, thus avoiding further fragmentation in the system. The difference in benefit coverage between those under social security and those with Seguro Popular, as well as difference in the quality of providers in the two systems, may act as a barrier to the longer-term goal of a more fully-integrated system.

The Law on Social Security has been recently modified with respect to pensions. Nonetheless, financing problems for IMSS remain during the transition period, in the short and medium term. Improving the cost-effectiveness of IMSS and ISSSTE remain important policy goals as well.

Table 1 Indicators of health status in OECD countries

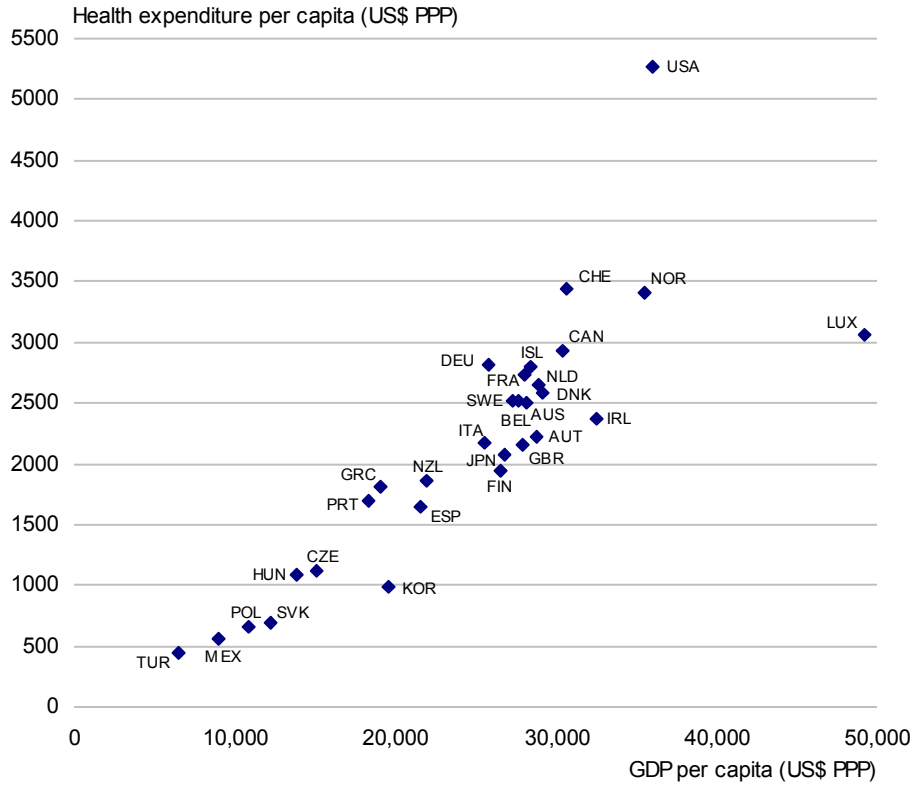
	Life expectancy Females years		Life expectancy Males years		Infant mortality rate	Maternal mortality rate
	at birth	at 60	at birth	at 60		
Australia	82.6	25.2	77.4	21.4	5	4.8
Austria	81.7	24.1	75.8	20.2	4.1	2.6
Belgium	81.1	23.9	75.1	19.6	6.1	8.6
Canada	82.2	24.9	77.1	21	5.2	7.8
Czech Republic	78.7	21.5	72.1	17.3	4.2	3.2
Denmark	79.5	22.4	74.8	19.1	4.4	13.6
Finland	81.5	24	74.9	19.5	3	5.4
France	83	25.8	75.8	20.8	4.1	6.5
Germany	81.3	23.9	75.6	19.8	4.3	2.9
Greece	80.6	23.1	75.5	20.1	5.9	6
Hungary	76.7	20.9	68.4	16.1	7.2	8.3
Iceland	82.3	24.4	78.5	21.8	2.2	0
Ireland	80.3	22.9	75.2	19.2	5.1	11.6
Italy	82.9	24.8	76.8	20.4	4.7	2.7
Japan	85.2	27.4	78.3	21.9	3	7.3
Korea	80	22.8	72.8	18.1	6.2	15
Luxembourg	81.5	24.2	74.9	19.6	5.8	18.6
Mexico	**77.4**	**22.3**	**72.4**	**20.4**	**21.4**	**76.1**
Netherlands	80.7	23.5	76	19.5	5	9.9
New Zealand	80.9	23.9	76	20.3	6.3	8.8
Norway	81.5	24	76.4	20.2	3.9	5.3
Poland	78.7	22	70.4	17.1	7.5	5.4
Portugal	80.5	23.3	73.8	19.4	5	2.5
Slovak Republic	77.8	21	69.9	16.4	7.6	7.9
Spain	83.1	24.9	75.7	20.3	3.4	4.2
Sweden	82.1	24.3	77.7	20.9	2.8	4.4
Switzerland	83	25.3	77.8	21.4	4.5	6.4
Turkey	70.9	18.1	66.2	16	42.6	49.2
United Kingdom	80.4	23	75.7	19.4	5.3	6
United States	79.8	23.4	74.4	20.1	6.8	9.9
OECD Average	80.7	23.5	74.8	19.5	6.2	8.4
Standard deviation	2.6	1.8	2.9	1.6	7.1	8.8

Source: OECD HEALTH DATA 2004, 2nd edition. MOH, 2004 for Mexican data.

IMR: deaths per 1000 live births ; MMR deaths per 100000 live births

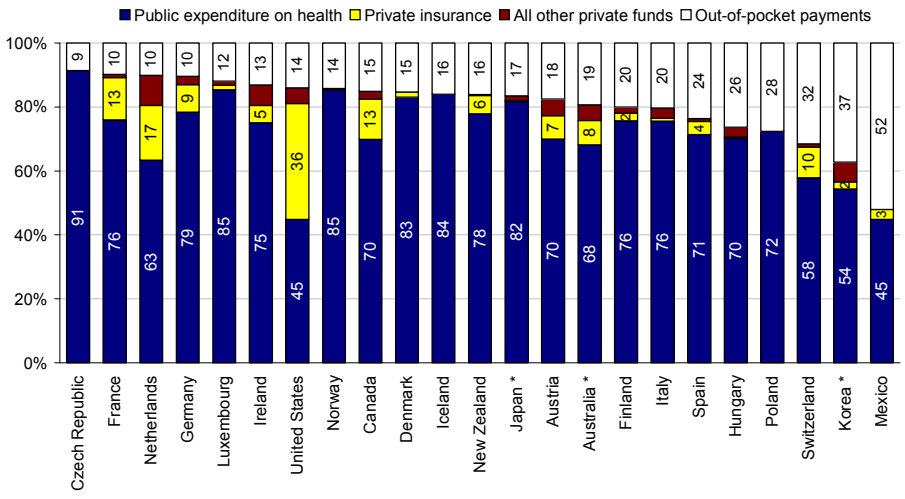
All data refer to early 2 000's except for Greece which refers to 1999.

Figure 1. Health expenditure and GDP per capita, 2002



Source: *OECD Health Data 2004, 3rd edition*.

Figure 2. Health expenditure by source of funding, 2002 (1)



(1) Countries are ranked by increasing share of out-of-pocket payments
Source: OECD Health Data 2004, 1st edition. * 2001