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Foreword

This is the OECD's second *Health System Review of Mexico,* published as reforms to Mexico's *Ley General de Salud* are being debated. Much progress has been made since the first review, a decade ago. Public investment in the health system has risen from 2.4% GDP to 3.2%; the publicly-subsidised health insurance plan *Seguro Popular* now covers around 50 million Mexicans, and reports of recent impoverishing health expenditure have fallen from 3.3% to 0.8% of the population. Many of Mexico's policy innovations are studied and emulated across the world, particularly in the field of prevention. Infant and maternal mortality rates have fallen, and life expectancy is now just under 75 years.

But major problems remain. Most critically, Mexico's "health system" persists as a cluster of distinct sub-systems, each offering different levels of care, to different groups, at different prices, with different outcomes. Affiliation to a sub-system is not determined by need, but by a person's job. Coupled with this inequity, inefficiencies are rife. Millions of Mexicans belong to more than one insurance scheme and many millions more, when surveyed, appear not to know that they have any health insurance at all. The share of the national health budget spent on administration, at around 10%, is the highest in the OECD. Individuals' out-of-pocket spending on health care is also amongst the highest in the OECD signalling, to some extent, a failure of current arrangements to provide effective insurance, high-quality services, or both. All stakeholders agree that Mexico needs to build a more equitable, efficient and sustainable health system.

This review identifies the right steps, in the short and medium term, to make reform happen. Given that major structural reorganisation is unlikely in the near future, the initial focus must be on extending service-exchange agreements (or *convenios*) so that the sub-systems – from a functional point of view – become more unified. High-cost diseases, maternity care, and elective surgical procedures are obvious candidates for new *convenios*. But primary and preventive care should not be forgotten: international experience in defining packages of care for diabetes and other chronic diseases should be followed. Mexico should also establish a new agency, independent of the Ministry of Health and the social security institutes, to assure, monitor and continuously improve quality of care. A renewed focus on outcomes and patient experiences will allow individuals the right information to choose one service provider over another, and ensure that *convenios* become living and active agreements. Progress in these areas can also be accelerated by creating a new commission that works to align care pathways, prices, information systems and administrative practices across sub-systems.

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Acronyms and abbreviations

AGENAS	Italy's National Agency for Regional Healthcare
AMI	Acute myocardial infarction
CAUSES	*Catálogo Universal de Servicios de Salud* (Universal Health Services List)
CBCISS	*Cuadro Básico y Catálogo de Insumos del Sector Salud* (Basic Formulary Medications List and Healthcare Supplies Catalogue)
CCNPMIS	*Comisión Coordinadora para la Negociación de Precios de Medicamentos y otros Insumos para la Salud* (Co-ordinating Commission for the Negotiation of Prices of Pharmaceuticals and other Health Inputs)
CENETEC	*Centro Nacional de Excelencia Tecnólogica en Salud* (National Centre for Health Technology Excellence)
CNPSS	*Comisión Nacional de Protección Social en Salud* (National Commission for Social Security and Health)
COFEPRIS	*Comisión Federal para la Protección contra Riesgos Sanitarios* (Federal Commission for the Protection against Health Risk)
CONAPO	*Consejo Nacional de Población* (National Population Council)
CONEVAL	*Consejo Nacional de Evaluación de la Política de Desarrollo Social* (National Council for the Evaluation of Social Development Policy)
COPD	Chronic obstructive pulmonary disease
CSG	*Consejo de Salubridad General* (General Health Council)
DRG	Diagnosis-related group
EHR	Electronic health records
ENOE	*Encuesta Nacional de Ocupación y Empleo* (National Labour Force Survey)
ENSANUT	*Encuesta Nacional de Salud y Nutrición* (National Survey of Health and Nutrition)
ETS	*Evaluación de Tecnologías Sanitarias (*Evaluation of Health Technologies)

FASSA	*Fondo de Aportaciones para los Servicios de Salud* (Fund for Allocations for Health Services)
FFS	Fee for Service
FPGC	*Fondo de Protección Contra Gastos Catastróficos* (Fund for Protection against Catastrophic Expenses)
GDP	Gross domestic product
GP	General practitioner
HIV	Human Immunodeficiency Virus
HTA	Health Technology Assessment
IMSS	*Instituto Mexicano del Seguro Social* (Mexican Institute of Social Security)
INDICAS	*Sistema Nacional de Indicadores de Calidad en Salud* (National System of Health Quality Indicators)
INEGI	*Instituto Nacional de Estadística y Geografía* (National Institute of Statistics and Geography)
ISES	*Instituciones de Seguros Especializadas en Salud* (Specialised Health Insurance Institutions)
ISSFAM	*Instituto de Seguridad Social para las Fuerzas Armadas Mexicanas* (Social Security Institute for the Mexican Armed Forces)
ISSSTE	*Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado* (Institute for Social Security and Services for State Workers)
ISTC	Independent Sector Treatment Centres
MoH	Ministry of Health
MXN	Mexican peso
OPD	*Organismo Público Decentralizado* (Decentralised Public Organization, or arm's-length body)
PAC	*Programa de Ampliación de Cobertura* (Coverage Extension Programme)
PEM	*Prescrição Electrónica Médica* (Portugal's Electronic Prescribing System)
PEMEX	*Petróleos Mexicanos* (Mexican Petroleum)
PHAMEU	Primary Health Care Activity Monitor for Europe
PPP	Purchasing power parity
PROSESA	*Programa Sectorial de Salud* (Sectorial Health Plan)
QOF	England's Quality and Outcomes Framework
R&AP	Regions and Autonomous Provinces

REPSS	*Regímenes Estatales de Protección Social en Salud* (State Insurance Regimes)
SEDENA	*Secretaría de la Defensa Nacional* (Ministry of Defence)
SEMAR	*Secretaría de Marina* (Ministry of Navy)
SHS	State Health Services
SICALIDAD	*Sistema Integral de Calidad en Salud* (Integral Health Quality System)
SINAIS	*Sistema Nacional de Información en Salud* (National Health Information Database)
SINAVE	*Sistema Nacional de Vigilancia Epidemiologica* (National System for Epidemiological Vigilance)
SINOS	*Sistema nominal en salud* (Personalised Health System)
SP	*Seguro Popular* (Publicly-subsidised insurance)
SS	*Seguridad Social* (Social Security, or contributory social insurance)
SSA	*Secretaría de Salubridad y Asistencia* (Ministry of Public Health and Assistance, now the Ministry of Health)

Executive summary

Ten years after the introduction of publicly-funded universal health insurance, and its first OECD *Health System Review*, the Mexican health system has unquestionably made progress. With the introduction of *Seguro Popular* in 2004, some 50 million Mexicans previously at risk of unaffordable health care bills now have access to health insurance. Reports of recent impoverishing health expenditure have fallen from 3.3% to 0.8% of the population and key parameters such as infant mortality, and deaths from heart attacks or stroke, have improved. Serious and urgent challenges, however, have intensified. Between 2000 and 2012, rates of overweight or obesity increased from 62% to 71% of the adult population; one in three children is already overweight or obese. More than 15% of adults have diabetes - more than double the OECD average of 6.9%.

Public investment in Mexico's health care system has increased, from 2.4% to 3.2% GDP between 2003 and 2013. But whether this money is translating into tangible health gains is in doubt – key indicators suggest that the Mexican health system is not working as effectively or as efficiently as it could. At almost 10%, for example, the share of the national health budget spent on administration is the highest in the OECD. High out-of-pocket spending on health care also signals a failure of the health system to provide effective insurance, high-quality services, or both. Perhaps a result of this and other factors, the gap in life expectancy between Mexico and other OECD countries has unfortunately widened – from about four years to almost six years over the past decade.

This *Health System Review* examines the reasons why current arrangements might be failing to meeting Mexicans' health care needs and makes recommendations for building a stronger, fairer and more sustainable health care system.

A fundamental challenge is that Mexican health care is provided through a cluster of disconnected sub-systems. Each sub-system offers different levels of care, at different prices, with different outcomes. Individuals effectively have neither choice of insurance plan nor of provider network, since affiliation is determined by their job. Individuals in private salaried employment (and their families) are affiliated to a benefit package and one set of providers belonging to the Mexican Institute of Social Security (IMSS). If, however, they lose their job, then they are likely to have to enrol with *Seguro Popular* – with a different package and different set of providers. If they then find work as a federal government employee, they will become affiliated to a different package and different set of providers belonging to the Institute for Social Security and Services for State Employees (ISSSTE). This is evidently disruptive for continuity of care. It is also wasteful, because individuals need to repeatedly re-engage with multiple systems. As currently arranged the Mexican system is bad for patients and bad for taxpayers.

Mexico's health system must change to deliver people-centred, high-quality care

Without far-reaching reforms, Mexico runs the risk of maintaining a fragmented health system with marked inequalities in access and quality, further entrenching socioeconomic disadvantage. An inefficient, unresponsive health system will hold Mexico back from

achieving the health, prosperity and progress of which it is certainly capable in coming years. As reforms to Mexico's *Ley General de Salud* are being debated, now is the time for the same level of ambitious and far-reaching reform that the health system has demonstrated in the past.

Mexico's health system must move from being a set of vertical subsystems whose operations are rigidly determined by historical and institutional legacies, to one that is responsive to the changing needs of individuals and communities across the life course. Given that major structural reorganisation is unlikely in the near future, Mexico's initial focus must be on extending service-exchange agreements (or *convenios*) so that the sub-systems, at least from the user's point of view, are more functionally unified. These agreements have been used sparingly in the past, and have mainly taken the form of social security institutes purchasing services from *Seguro Popular* to alleviate capacity constraints (particularly in the case of diagnostic tests) – rarely the other way around. Further opportunities to expand the application of *convenios*, at both state and national level, should be sought. Immediately apparent examples include elective surgery, maternity care or other self-contained interventions. It would also make sense to standardise care and prices for high-cost services, such as renal dialysis, or care for HIV. But primary and preventive care should not be forgotten. In particular, Mexico should follow extensive international experience in defining and pricing packages of care for chronic diseases such as diabetes.

To ensure that new *convenios* become living and active agreements, rather than remaining dormant and unused, another key step will be to re-energise thinking on monitoring and improving health care quality. Planning for a new quality monitoring and improvement authority should be accelerated. This national agency, independent of the Ministry of Health and the social security institutes, should be responsible for setting standards for safe and effective care across all providers, including private ones. An independent quality agency should also be attributed powers to collect, analyse and publish quality and outcomes data, sharing the lessons of good performance and supporting poorly performing units. This will give individuals the right information and the right incentives to choose one service-provider over another and encourage continuous quality gains.

Closer functional unification can also be accelerated by establishing a forum, or commission, that brings *Seguro Popular* and the social security institutes together to focus on technical matters of common interest. This commission would offer a shared resource to align care-pathways, prices, information systems and administrative practices, as well as identify interventions where quality and price can be easily standardised to enable exchange of services. Mexico should consider redefining the benefits package offered by the social security institutes, and introduce clear separation of the purchaser and provider functions. The purchaser side should demand better information on activities, costs and outcomes from the provider side, enabling transparent, intelligent purchasing and ensuring that only high-value services are funded. These activities will lay the foundations for a fully unified, equitable and sustainable health care system in the longer term.

Assessment and recommendations

Ten years after the introduction of publicly-funded universal health insurance, the Mexican health system finds itself at a critical juncture. Unquestionably, some measures of health and health system performance have improved: those previously uninsured now use health services more often, whilst numbers reporting impoverishing health expenditure have fallen from 3.3% to 0.8%. Infant mortality fell to 13.0 deaths per 1 000 live births in 2013, a 38% reduction since 2000. Other indicators, however, remain worrying. Rates of survival after heart attack or stroke are markedly worse than in other OECD countries. Failure to modify lifestyles which harm health is a particular concern: with 32% of the adult population obese, Mexico ranks as the second most overweight nation in the OECD and almost one in six adults are diabetic. Other key metrics imply deep-rooted inefficiencies in the system: administrative costs, at 8.9% of total health spending, are the highest in the OECD and have not reduced over the past decade. Likewise, out-of-pocket spending is around 45% of total health spending[1] – the highest in the OECD.

In short, Mexico's public investment in its health system, rising from 2.4% to 3.2% GDP between 2003 and 2013, has failed to translate into better health and health system performance to the extent that one would have wished. A programme of continued, extensive reform is needed. Mexico needs an equitable, efficient, sustainable and high quality system of health care. This will not be delivered by its current fragmented health care structure, with different levels of care for different groups, provided at different prices with different outcomes. Instead, Mexico needs a functionally unified health system, where access is determined by need, not by employment status. Individuals should have some choice over insurer and provider, to drive efficiency and continuously improve quality. This report sets out the OECD's recommendations on the steps Mexico should take to achieve this. It is essential that modernisation starts now. If not, the Mexican health system, whether through financial non-sustainability of some institutions, or a deluge of *recursos de amparo* (constitutional appeals) for health care rights, risks becoming enveloped in crisis.

Mexico faces complex and challenging health care needs

Although the Mexican population is young, with around nine people of working age for every adult aged over 65 (more than double the OECD average), it faces complex and challenging health care needs. Mexico now has the lowest life expectancy of all OECD countries. While life expectancy increased by three years on average across OECD countries between 2000 and 2013 (rising from 77.1 years to 80.4 years), it increased by only 1.3 years in Mexico (from 73.3 to 74.6 years). This means the gap in longevity between Mexico and other OECD countries has widened from about four years to almost six years.

A particularly worrying concern is Mexico's high rates of overweight and obesity. Between 2000 and 2012, rates of overweight or obesity increased from 62.3% to 71.3% of the adult population; one in three children is also overweight or obese. Unsurprisingly, diabetes, the chronic disease most directly linked with obesity, is spreading rapidly and now affects many adults. In Mexico, 15.9% of adults have diabetes, more than double the OECD average of 6.9%.

Partly as a result of these adverse risk factor profiles, deaths from cerebrovascular diseases (strokes) have only fallen by 38% since 1990 – a modest decline compared to the average reduction of 54% across OECD countries. More disconcertingly, deaths from heart disease have decreased by only 1%, in sharp contrast to the 48% reduction seen across other OECD countries. Given that the Mexican population is now ageing more rapidly than any other OECD country, there is little reason to hope that these adverse trends can be reversed without a substantial strengthening of the health system.

Adding to this worrying epidemiological picture, Mexico's social and demographic context also presents significant challenges. Health and prosperity continue to be unequally distributed, with people in southern states, women, children and indigenous groups leading notably disadvantaged lives. Despite major redistributive reforms, poverty remains endemic. The National Council for the Evaluation of Social Development Policy (CONEVAL) finds that just under 10% of the population still lives in extreme poverty (although this figure is decreasing) and Mexico is the second most unequal country in the OECD area after Chile. Per capita incomes in the richest states are between four and six times higher than per capita income in poorer, southern states. About three quarters of indigenous peoples in Mexico live in poverty, compared to around four in ten non-indigenous people.

High rates of work in informal jobs continue to be a feature of the Mexican labour market: almost 60% of Mexican employment is in the informal sector (although new formal sector jobs are rapidly being created). Approximately 22% of Mexican youth are neither in formal employment, education or training (9.4% of men and 34.7% of women aged 15 to 29), compared to 15% on average across OECD countries. These high rates of informal employment inevitably limit the revenues available to resource publicly-funded health care and other forms of social protection: public spending on wider social protection is the lowest in the OECD area, accounting for 7.9% (2012) of GDP, about one-third of the OECD average of 21.6%.

To meet this challenging constellation of circumstances, Mexico needs a health system that is responsive to people's changing needs, capable of offering continuous, personalised care, proactive and preventive in orientation as well as being cost-effective and sustainable. An analysis of current arrangements, however, suggests that this is far from the case.

Current arrangements are failing to meet Mexicans' health care needs adequately

Currently, health services in Mexico are provided through a variety of sub-systems – multiple insurers employing their own staff to deliver health care in tied facilities, with an individual's affiliation usually determined by their employer. The largest of these is the *Instituto Mexicano del Seguro Social* (IMSS), which provides health insurance and health care services (as well as pensions and a range of other benefits) principally for Mexicans in salaried private (formal) employment. The *Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado* (ISSSTE) provides similar social security (SS) for federal government employees. Other key institutions include the network of *Servicios Estatales de Salud,* or government-funded State Health Services (SHS), for those without employment-linked insurance.

The most important health system reform of recent years was the introduction of *Seguro Popular* (SP) in 2004, which extended publicly-funded health insurance to 50 million Mexicans who were previously uninsured. Prior to *Seguro Popular,* these individuals would have had access to SHS but been liable to a user-fee. Now, nearly all Mexicans have access to a health insurance plan. The package of services covered by *Seguro Popular* has

been continuously expanded, such that it now reportedly covers 95% of presentations to clinics and hospitals, and 97% of those using *Seguro Popular* report satisfaction with the health care services received.

Affiliation to SP has grown from around 5m individuals in 2004 to around 50m in 2014, according to CONEVAL data. The significant increase in SP affiliation represents an important step towards universal health coverage (UHC). Nonetheless, according to the same surveys, 18% of the population report not having any health insurance – signalling a lack of awareness that is likely to translate into poor health care access, poor outcomes and continued financial risk.

Box 0.1. Progress since the publication of the *OECD Health System Review: Mexico,* in 2005

Ten years ago, the OECD undertook a review of the Mexican health system. That review made detailed recommendations for improving health system performance in six areas: 1) ensuring adequate funding of the health system; 2) tackling the remaining barriers in accessing services for those not covered by social security; 3) encouraging greater efficiency of health care providers; 4) encouraging greater productivity of health care professionals; 5) promoting the quality and effectiveness of care; and 6) improving governance of the system.

Since then, relatively good progress has been made in the second and fifth of these areas. Regarding the former, *Seguro Popular* has gradually expanded its package, particularly for cancer and other the interventions covered by the fund for high-cost diseases. The National Survey of Health and Nutrition, ENSANUT, and work by the National Institute of Public Health suggest that service availability has generally improved, and availability of prescribed medications in particular. In rural areas, the Mobil Medical Units (formerly *Caravanas de la Salud*) programme, implemented in 2007, appears to have had some transitory benefit. Important challenges in service quality and availability persist, however, as set out in Chapter 3 of this report.

Regarding the promotion of quality and effectiveness, particular progress has been made in health promotion and disease prevention programmes. Mexico's national strategy against obesity, overweight and diabetes reflects international best practice (oecd.org/health/Obesity-Update-2014.pdf), and its internationally innovative tax on sugary drinks and high-calorie snacks was associated with reduced consumption. Good progress has also been made in the authorisation and safety of new technologies (through COFEPRIS, the Federal Commission for the Protection against Health Risk, and other bodies). Still, however, not enough is known about the quality and outcomes achieved by health care providers and a national approach to standards and guidelines for the quality of care remains lacking, as discussed in Chapter 2.

Progress in the other four areas of the 2005 review's recommendations, however, is disappointing. The level and sustainability of health system funding remains far from optimal (with the exception of impressive savings resulting from consolidated purchasing of pharmaceuticals), as set out in Chapter 4. Few efforts to improve the productivity and efficiency of providers (including health care workers) have materialised, as set out in Chapter 5. In particular, the 2005 review's recommendations to introduce a purchaser-provider split has not been implemented, apart from in a few scattered settings (such as Hidalgo state's experimentation with new payment methods, and in the SS institutes' contracting with private providers for certain high-demand interventions, such as obstetrics or haemodialysis). The model of workforce contracts remains largely the same. System governance, too, remains largely unreformed. Apart from very occasional convenios to allow SP and the SS institutes to exchange services, few mechanisms have been created to support closer working across the sub-systems. In particular, information systems across the SP and the SS institutes remain incompatible and a national patient register or census (a minimum requirement to enable interoperability and closer working) does not exist.

Resourcing is unequal across sub-systems, out-of-pocket payments remain high and deep-rooted inefficiencies persist

There are considerable gulfs between individuals' health care entitlements on paper and their experiences in reality, with those covered by SP facing particular disadvantage. Health care in Mexico is less well-resourced than in other OECD countries. Currently, Mexico spends 6.2% (2013) of GDP on health, somewhat less than the OECD average of 8.9%, equating to USD PPP 1 048 per capita per year (OECD average USD PPP 3 453 in 2013). The share of this spend coming from public sources is particularly low. Only Chile (46%) and the United States (48%) report a share of public spending on health lower than Mexico (51%). The low public spending and limited total investment in the health system is reflected in national health resources. Mexico has 2.2 practicing doctors and 2.6 practicing nurses per 1 000 population, much less than the OECD averages of 3.3 and 9.1, respectively. Bed density is also markedly low, with 1.6 beds per 1 000 population in 2013, compared to 4.8 beds per 1 000 OECD-wide: again, the lowest amongst OECD countries.

In addition, effective resourcing does not appear equal across the health sub-systems. Although per capita total spending is now broadly similar for individuals with and without social security (at MXN 3 429 per capita for those without social security in 2013, compared to 3 505 for IMSS and 3 945 for ISSSTE affiliates), differences in entitlement persist, involving some common and devastating illnesses. Heart attacks in those aged over 60, strokes, dialysis after renal failure, multiple sclerosis and lung cancer are not, for example, covered by SP. Some differences in access are also apparent. The number of specialist outpatient consultations is 319 per 1 000 enrolees within SP, for example, compared to 338 and 620 per 1 000 enrolees within IMSS and ISSSTE respectively. While some of these differences may reflect unequal need (such as ISSSTE's slightly older population), others cannot be justified in this way. The number of prescriptions that could not be fully dispensed by a pharmacist due to lack of stock is 33% within SP compared to 14% within IMSS according to survey data (although the SS institutes' own figures suggest higher rates of dispensed prescriptions).

Out-of-pocket spending in Mexico constitutes 45% of health system revenue[1] and 4.0% of household expenditure. Both of these figures are amongst the highest in the OECD. Out-of-pocket spending has not fallen significantly across the past decade, despite efforts to achieve universal health coverage through the SP reform. Reasons for sustained, high levels of spending out-of-pocket are unclear. Part of the reason may be dissatisfaction with the quality or accessibility of services provided by institutions to which individuals are affiliated, leading them to seek care from private health providers. Indeed, with 11.4 publicly-owned and 28.6 for-profit privately owned hospitals per million population, Mexico displays the highest ratio of private to public sector facilities across OECD countries for which data is available, indicating that the private sector is an important part of the overall health care system.

Poor performance on some indicators of quality of care underlines the urgency of reform. Nearly three in ten Mexicans die within a month of a heart-attack (and this rate is *worsening*), compared to less than one in ten across the OECD on average (where survival rates are generally improving). Likewise, nearly two in ten Mexicans die within a month of a stroke (with no improvement in survival rate over the last five years), compared to less than one in ten across the OECD on average (where survival rates are generally improving).

There is also good evidence that Mexico's scarce resources are not being used as effectively. Primary care is not as developed as it should be. Registration with a named primary care doctor is not established, for example, and opening hours are limited. People

seek episodic care, therefore, from hospital emergency departments (and increasingly from pharmacies offering consultations with a physician), meaning that opportunities for proactive, preventive and co-ordinated care are lost. Administrative costs, at 8.9% in 2013 of total health spending, are the highest in the OECD and have not reduced over the past decade. Most OECD countries are spending significantly less than this on health system administration, and many have made significant cuts since the 2008 financial crisis. Another source of inefficiency concerns the ten million or more Mexicans who, according to survey data, have duplicate (or occasionally triplicate and quadruple) health insurance. These individuals may be covered by their employment status and their spouse's insurance plan, for example.

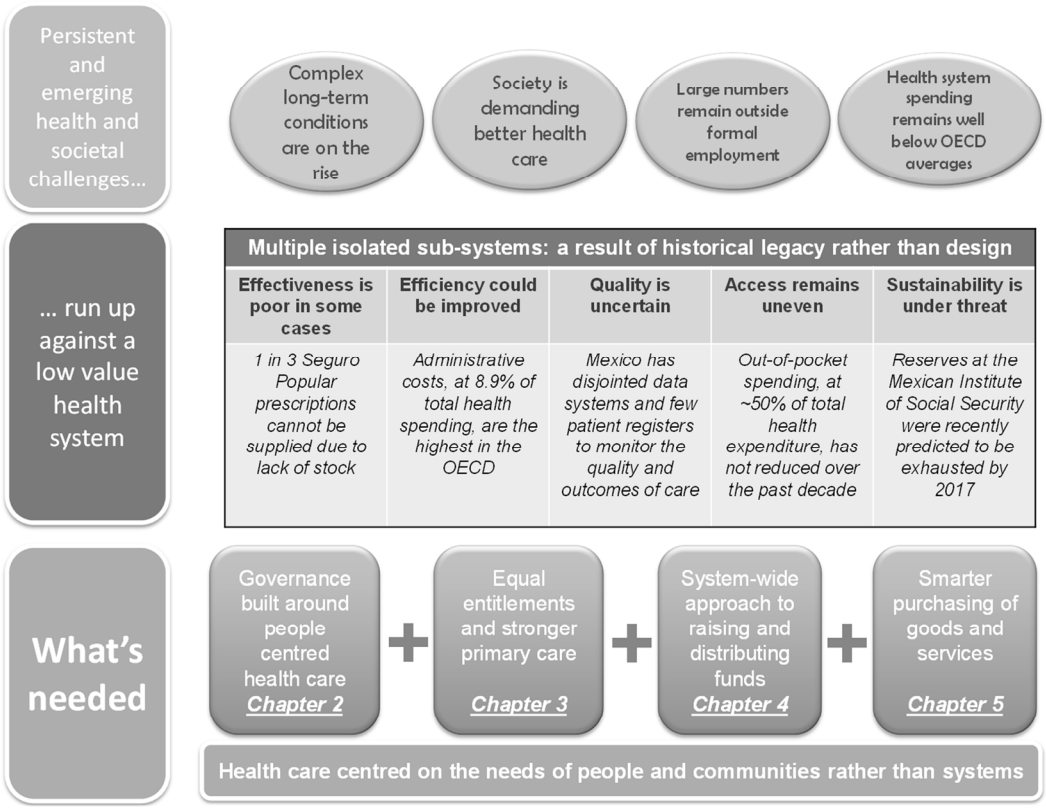
At the same time, around one third of SS affiliates each year are forced to change insurer/provider network because of a change in employment status, disrupting continuity of care. Individuals in private salaried employment (and their families) are affiliated to a benefit package and one set of providers. If, however, they lose their job, then they are likely to have to enrol with SP – with a different package and different set of providers. If they then find work as a federal government employee, they will become affiliated to a different package and different set of providers. This is evidently disruptive for continuity of care. It is also wasteful, given that multiple systems need to engage with the same individual. Incentives to for any one scheme to invest in prevention services are also weakened, since they may not see the return. As currently arranged the Mexican system is bad for patients and bad for taxpayers.

Sustained and comprehensive structural reforms to Mexico's health system are now needed

Mexico needs a health system that is centred on people's needs, rather than historical institutional arrangements, and that is capable of offering preventive and personalised care whilst being cost-effective and sustainable. Yet, in many respects, Mexico's health system is not performing as well as it should – access, quality, efficiency and sustainability could all be substantially improved. The foregoing paragraphs have demonstrated how current arrangements are failing on several fronts.

Without far-reaching reforms, Mexico runs the risk of maintaining a low-value health system that fails to address rapidly rising burdens of age- and lifestyle-related disease, as well as a two-tier health system with marked differences in access and quality, which risks further entrenching socioeconomic inequality. An inefficient, unresponsive health system, marked by persistent inequalities in quality and access, will unquestionably hold Mexico back from achieving the health, prosperity and progress of which it is certainly capable in coming years.

Figure 0.1. Current arrangements are failing to meet Mexicans' health needs



Mexico's health system must change to deliver people-centred, high-quality care

If Mexico's health system is to meet health care needs in a fair, effective and sustainable way, it must move from being a set of vertical sub-systems whose operations are rigidly determined by historical and institutional legacies, to one that is responsive to the changing needs of individuals and communities across the life course and that uses resources efficiently.

Such a system focussed on people-centred health care would prioritise responsive and accountable services, strongly oriented toward preventive and primary care, which make effective use of both the public and private sectors. At individual and community level, people-centred health care would emphasise the need to improve the management of long-term conditions by increasing continuity of care. At the level of health care organisations, people-centred health care would stress the need to address fragmentation. Continuity of care, multi-disciplinary collaboration and networks across primary and secondary care providers are particularly necessary in Mexico's health system.

Aside from good progress in improving preventive care, quality of care more generally has received relatively little policy attention in recent years – despite Mexico's poor performance on some international benchmarks of quality. Although systems to measure the quality of care are in place, they are not systematically used to drive improvement. Mexico would benefit from a more systemic and sustained approach to quality monitoring and improvement that matches best practice internationally. This would include strengthened arrangements for professional licensing, continuing professional education,

accreditation of health care facilities, development of national standards and guidelines and publishing national audits of the quality of care.

Planning for *a new quality monitoring and improvement authority* should be accelerated. This national agency, independent of the Ministry of Health and the SS institutes, should be responsible for setting the required standards for safe and effective care across all providers in the system, including private ones. A particular priority will be to develop national standards and guidelines for care, and monitor and encourage adherence to them. This is a sphere of quality improvement that currently receives insufficient attention in the Mexican health system. An independent quality agency should also be attributed the necessary regulatory powers to collect, analyse and publish quality and outcomes data, sharing the lessons of good performance and supporting poorly performing units. Recent reforms in Italy, and in particular, the recently created National Agency for Regional Healthcare (AGENAS), are instructive here. AGENAS plays an important role in assuring convergence between the quality and efficiency approaches across Italy's 21 regional health systems especially in the field of indicator development, analysis and open comparative reporting.

Consolidating the collection, analysis and dissemination of health system information will be key to driving reform

Although a lot of data is generated in the Mexican health system, a fragmented approach to collection, validation, analysis and dissemination means that its full potential to inform policy and spur service improvements is rarely exploited. Health system managers, whether at national, state or institutional level, are rarely able to point to projects that have used data to identify areas of excellence or weakness, or that have been used as a basis for quality improvement work. Infrequent comparison and benchmarking of results is a linked problem, since even simple things such as waiting times are not measured consistently across Mexico's sub-systems.

A more consolidated information infrastructure will be essential to achieving high quality, people-centred health care. As a first step, all parties should commit to a *strategic review of information systems in current use*. This would address how Mexico can move from its current fragmented set of information systems to a nationally consolidated approach focussed on the following key data functions: continuous quality improvement, personalising care and ensuring continuity; supporting contracting and purchasing through clearer accountability for results; and, predicting changing health care needs and modelling new service configurations.

One concrete output to aim for would be a national, consolidated patient register or, at least, interoperable registers of affiliates across sub-systems, which would equate to the functional equivalent of a single national register. This could be achieved by integrating patient data already held by the states and the SS institutes, although is likely to involve substantial work in resolving conflicting or duplicating data. Technical and legal safeguards will also need to be in place to assure an acceptable level of data security. Once this essential minimum of a national patient register is established, the focus should then be on consolidation and interoperability of the various additional databases used by SP and the SS institutes.

Further development of the national health information system should be informed by the work of the new quality monitoring and improvement authority referred to above. Agreed common care pathways and minimum quality standards should form the basis of a set of *nationally applicable performance indicators*. These would then drive quality

benchmarking across providers and underpin continuous quality improvement. Indicators that can be constructed from already routinely collected data, such as waiting time for a doctor appointment and user satisfaction, should be prioritised initially. Work is underway to design and implement a national dashboard of quality and efficiency metrics, consistent across all insurers/providers, and this should be accelerated.

OECD countries offer numerous examples to emulate. In Sweden, for example, the National Board of Health and Welfare and the Swedish Association of Local Authorities and Regions (SALAR) regularly publish counties' performance across more than 150 indicators of health care quality and efficiency, drawn from Sweden's extensive set of national patient registers. In primary care, Denmark and Israel have both developed highly effective performance reporting systems, applied across all primary care providers with results made publicly available. In Finland, the *PERFormance, Effectiveness and Cost of Treatment* (PERFECT) project links individuals' data to report outcomes and costs for whole pathways of care for patients with breast cancer, schizophrenia and several other conditions. *A unique patient-identifier, used consistently across all health care providers*, needs to be developed as a priority since this is clearly fundamental to the project's success. Mexico's *Clave Única de Registro de Población*, or system of personal ID numbers, should facilitate this.

Other important gains from a richer information infrastructure come from better matching services and supplies. Mexico should put in place *mechanisms that allow patient numbers, service volumes, costs and outcomes to be analysed for specific patient groups*, and use this intelligence to optimise purchasing and contracting. The same information could also be used to predict evolving health care needs and model potential service reconfigurations, to ensure that the health system remains responsive and appropriate to population health needs. Reforms in Portugal are illustrative here, and demonstrate success in optimising both cost and quality across numerous clinical areas including prescribing, day-case surgery and care for chronic conditions.

Work to develop personal electronic health records (EHR) should continue, since these have great potential to support continuity of care, higher quality care and greater patient involvement in self-management. Mexico has a number of evolving initiatives in this sphere; hence close co-ordination will be required to ensure a common framework and interoperability across them. Steps to *establish a system-wide, independent regulator for data* who can oversee the expansion of electronic health records will be necessary. It will also be crucial to ensure that the legal framework around data privacy supports record sharing whilst affording adequate safeguards. The OECD's work on balancing the public value and individual privacy of health care records compiles international experience in this area, and offers substantial guidance.

Defining an equal benefits package and strengthening primary care

A core policy priority in Mexico must be to achieve equality in the package of services covered by the different insurance sub-systems. This will promote equity as well as quality and efficiency, by enabling better continuity of care. Very close convergence between the SP and SS packages has been achieved, particularly for primary care, although the fund for high-cost treatments (the *Fondo de Protección Contra Gastos Catastróficos*, FPGC), continues to omit important secondary and tertiary care treatments for those in the SP system. The priority must be to ensure that what appears as an entitlement on paper can in fact be realised in practice, because gaps in accessibility and quality between SP and SS continue to exist for both primary and secondary care.

More effective health technology assessment is needed across the Mexican health system

Strengthening Mexico's capacity in Health Technology Assessment (HTA) will be central to sustainable and efficient health care funding in the future. At the moment, this function is performed by the *Centro Nacional de Excelencia Tecnólogica en Salud* (CENETEC). CENETEC was created at the same time as SP. Although the original intention was that it should function as an HTA agency (modelled, to some extent, on the United Kingdom's *National Institute for Clinical Excellence*), most of its work in fact relates to promoting good use and management of medical technologies such as telemedicine, rather the assessment of new pharmaceuticals. CENETEC also supports a network of around 70 experts who teach and promote the use of HTA. In addition to its work on novel equipment and devices, CENETEC is increasingly assessing medications as well.

Resolution of these somewhat limited arrangements presents an opportunity to strengthen Mexico's HTA capability. CENETEC should be built up and take on a more extensive role in producing HTAs. Analyses should not just be applied to new treatments but to existing ones as well, to encourage value for money across the system. Rather than just focussing on services for the uninsured, CENETEC's remit should expand to cover the SS institutes as well. *Expansion of CENETEC's role will require increased investment*, and modification of its legal status may also be necessary. Currently, it operates as a subsidiary unit within the Ministry of Health and is limited in its ability to contract with external bodies. It cannot, for example, outsource work to research institutes or easily collaborate internationally. *Re-establishing CENETEC as an independent arm's-length body* (*Organismo Público Decentralizado*, OPD) would solve this issue. It would also, most likely, increase the strength and legitimacy of CENETEC's work.

Social security institutes should take steps to define their benefits package more clearly

At the same time as expanding SP's benefit package (explicitly defined in the *Catálogo Universal de Servicios de Salud*, CAUSES) and SP's *Fondo de Protección Contra Gastos Catastróficos*, Mexico should consider *defining more explicitly the health care covered by the social security institutes*, to ensure that only high-value services are funded. The 2008 global financial crisis has meant that many OECD countries explored options around reducing the publicly-funded benefit package. Estonia withdrew coverage for dental checks for adults, for example. Portugal has delisted some over-the-counter drugs and Greece has re-introduced a positive list for pharmaceutical coverage. The Czech Republic is also undertaking a review of all medicines to determine whether or not they should be publicly funded.

For Mexico, a plausible initial step in this direction would be to develop a national positive list of treatments for high-cost diseases (such as HIV or certain cancers), applicable to both SP and SS affiliates. International experience would support an explicit list of entitlements. With few exceptions, for example, all OECD countries have a nationally established list defining which medications are covered by their insurance schemes.

Secondary private health insurance can play a useful role in preserving access to services which are deemed to be of marginal value (from a societal perspective), but which are nonetheless valued by some individuals. Secondary insurance plays a role in almost all OECD health systems. Of particular note given structural similarities to Mexico, secondary insurance in Israel is very common. There, supplemental insurance is purchased by some 80% of the population, for services that are not included in the basic benefit package. In the

Netherlands and New Zealand, secondary insurance covers supplemental benefits, such as dental care, physiotherapists, glasses and contact lenses and some forms of alternative medicine. In Italy, secondary insurance also covers cost-sharing for diagnostic tests, specialist consultations, pharmaceuticals and long-term care.

Reflecting these international practices, the Mexican authorities should establish what legal, financial and logistical steps would be necessary to offer secondary insurance to SP and SS affiliates, for certain services. A good first step would be in-depth study of how supplementary insurance operates (and was introduced into) structurally similar health systems, such as the Dutch or Israeli systems. Parallel work should identify which services in Mexico would be politically most feasible, and economically most astute, to place at the margin of the benefits package. This will most likely be lower value treatments (such as non-generic drugs). Risks around introducing secondary insurance should be carefully considered – including adverse impacts on equity and out-of-pocket spending.

Mexico urgently needs a renewed and strengthened preventive and primary care function

Other, more far-reaching, policy priorities must also be addressed. Beyond achieving equality across the SP and SS packages, the model of service delivery across all sub-systems needs to be transformed if Mexico is to meet the rapidly evolving health care needs of its population in an efficient and sustainable manner. A key aim must be to *reduce dependence on the hospital sector and pivot service delivery decisively toward primary and preventive care*, delivered closer to where people live and work. This is a priority that all OECD health systems are pursuing, in order to better provide the co-ordinated, preventive care needed for long-term conditions and multi-morbidity.

Mexico is widely heralded for its ambitious and comprehensive approach to tackling diabetes, high blood pressure and other chronic diseases through public health programmes and public policy. Initiatives such as the *Acuerdo Nacional por la Salud Alimentaria*, *Consejo Nacional para las Enfermedades Crónicas*, *Estrategia Nacional para la Prevención y el Control del Sobrepeso, la Obesidad y la Diabetes* (with is widely-known campaign *Chécate Mídete Muévete*), constitutional reforms prohibiting unhealthy foods in schools, consumption taxes and other regulations, clear food labelling and most recently restrictions on advertising unhealthy foods during children's typical television and cinema viewing times, have all captured international interest.

Yet secondary prevention (i.e. the early detection and adequate treatment of chronic diseases) is much less well delivered. Data from ENSANUT (Mexico's National Health and Nutrition Survey) show that, of those found to have high blood pressure (an important and treatable risk factor for strokes and heart attacks), 47.3% were unaware that they had the condition. Of those aware, only 73.6% were receiving treatment and less than half of these had their blood pressure adequately reduced. Similarly, of those known to be diabetic, 14.2% (almost 1 million Mexicans) had not seen a doctor for routine management of the condition in the past year. This means that diabetes is very poorly treated at population level: 24.7% of diabetics were found to be at high risk of complications such as strokes, heart attacks, renal failure or loss of vision and 49.8% at very high risk.

Strengthening preventive and primary care

In all OECD countries – in the face of an increasing prevalence of chronic conditions and concerns about fiscal pressures – primary care systems are being asked to take on a bigger role and demonstrate better value for money. Mexico, too, should be looking to

strengthen this sector and see it make a bigger contribution to meeting Mexicans' health care needs. Preventing ill-health from developing in the first place will need to be at the forefront of activity. Given its rapidly evolving population health care needs and fiscal constraints, *Mexico should develop primary care as a distinct medical speciality*. It would be worth investing serious effort to develop a national vision for primary care, to counter any misconception that primary care is merely health care for the poor or marginalised. In defining a new speciality of primary care, the most important task will be to distinguish the current cohort of physicians working as community generalists (who do not have substantial specialist post-graduate training) from future primary care specialists. This distinction should be unambiguously evident to patients and other health care professionals, and be based upon extended knowledge, skills, roles and responsibilities. The application of clear licensing criteria should underpin this in practice.

A core function of a strengthened primary care sector must be the effective management of patients with multiple, complex health care needs, including long-term conditions such as diabetes. *Creation of academic departments of primary care* in Mexican medical schools to undertake research in primary care, develop clinical guidelines specific to primary care, as well as teach the speciality, would support this. *Development of the information infrastructure underlying primary care* will also be critical, so that a richer picture of the effectiveness, safety and patient centredness of primary care can be built. Candidate indicators would be around prevention and management of chronic diseases, elderly care, child health and mental health care, as well as patient experience. Linked to this, Mexico should consider the *introduction of a system to allow all patients to register formally with a named primary care specialist*, as happens in the SS institutes and in many other OECD health systems. This would support continuous, co-ordinated care as well as allow calculation of quality indicators for specific patient groups (such as rate of adequate blood pressure control amongst diabetics).

Consolidating and expanding the revenue base for Mexican health care

Compared with the public spending of other OECD countries, total government spending on health care in Mexico is low. Mexico spends less of its gross domestic product on publicly funded health care (3.2% of GDP) than any other OECD country. Current levels of public funding are manifestly inadequate – as evidenced by unparalleled rates of out-of-pocket spending by Mexican individuals to meet their health care needs. *More generous public funding of the health system should be pursued* to deliver the modern, accessible health service its citizens want. To ensure that increased resources are not wasted but translate into better health outcomes, greater health system efficiency must be prioritised at the same time.

More generous and secure public funding for Mexican health system should be identified

Currently, the Mexican Ministry of Finance imposes a 2% growth limit on operating budgets in all sectors of federal spending. Without removing this cap, or *undertaking a health sector spending and efficiency review*, it will be difficult to increase health system resources substantially over a short period of time. Many other OECD countries, such as France or the United Kingdom, engage in regular spending reviews that allow a more responsive approach to public service development, whilst controlling over spending. The efficiency of revenue collection and distribution must also be improved. Large informal sectors, such as exist in Mexico, are unable to effectively collect payroll and consumption taxes, which leads to lower government revenues. Mexico has recently implemented a

range of fiscal reforms to raise public revenues by closing tax loopholes, reducing subsidies to petrol, and incentivising formal work by temporarily subsidising payroll contributions for new workers. Reforms such as these should be extended and deepened. Federal transfers to states should occur in a more predictable and timely manner than has been the case until now, to enable states to plan and deliver health services more effectively.

At the same time, Mexico should consider a *shift towards greater reliance on tax-based financing* of its health system, particularly for new revenues. It is important for health systems to ensure the stability and predictability of revenues to maintain quality health care services. In this sense, social insurance contributions can be less reliable sources of funding than general taxes, particularly if there are fluctuations in employment levels. Research has also shown that direct taxes have a stronger redistributive effect than social health insurance. In Mexico, payroll contributions will remain an important source of health system funding in the medium term. Nevertheless, relying more on general tax for new revenues could eventually shift the locus of revenue generation away from the schemes themselves, making it more politically feasible to allocate resources according to need. Other countries' experience demonstrates how an incremental approach to greater tax-based financing of Mexico's health system could be achieved. In Lithuania, for example, the state budget makes a flexible contribution to the health insurance fund based upon average wage levels over recent years, thus stabilising revenues during times of high unemployment.

Financial resources also need to be more efficiently allocated to reflect regional health needs

Better resource allocation is also needed. Currently, resources from *Seguro Popular* are allocated primarily through transfers to states. There are basically three types of funding: 1) the *Cuota Social*, which provides the same per person funding level for each affiliated individual; 2) the *Aportación Solidaria Federal,* which are funds directed at specific health sector programmes in a state and also seeks to adjust for need, combined with a small (1.25%) performance-linked component; and 3) the *Aportación Solidaria Estatal*, which represents the state's own contribution and is meant to be equivalent to half the *Cuota Social.* Resource levels are largely based on the number of affiliated individuals within a state, as an 80% weight is attached to the size of the affiliated population (being the most easily measured dimension of the formula).

This resource allocation approach was appropriately designed in the early stages of SP, because it incentivised states to enrol more people. Funding levels have now plateaued, however, because nearly all Mexicans have affiliated. Resource allocation methods have historically not encouraged performance to an adequate extent, because greatest weight in the funding formula was given to the flat per capita component. Now is a good opportunity *to revise the regional resource allocation formula* to account for factors such as need, performance, transparency, accountability and capacity. To improve equity and quality in the short term, it would be productive to move from historical budgets to performance and need-based resource allocation. This should apply in both the SP and SS schemes.

At the same time, there is scope *to improve regional accountability for spending*. Under current Mexican law, the states are responsible for deciding how to spend their resources, which means that the Ministry of Health and the Ministry of Finance have limited levers to address concerns around efficiency or quality. There are, however, broad rules regarding how states can use their health funds, which is important given the variations in administrative and managerial capacity across states. No more than 40% of SP funds can go to human resources, for example, and no more than 30% can be spent on pharmaceuticals with a minimum of 20% on preventive activities. Yet beyond these figures, there is no clear

resource allocation strategy at the state level, leaving states responsible for how they spend resources within these restrictions.

One option to improve accountability is to give states a financial incentive to provide better reporting. For example, Italy has also been faced with a comparable situation to Mexico, having significant variation in administrative and managerial capacity across regions in a largely decentralised setting. Since the beginning of the 2000s, regions have been able to obtain additional resources conditional on improved reporting of health service activities, costs and outcomes. In 2007, highly indebted regions receiving additional funds were required to submit quarterly progress reports describing the extent to which predetermined policy objectives were being met. Alternatively, the central government could withhold some funds if states' administrative data is of insufficient quality to allow proper performance monitoring.

Allowing Mexicans to maintain insurer affiliation after changes in employment would promote continuity of care

Achieving a national, unified benefits package and working toward the continuity of care that is so vital if Mexico is to adequately tackle its crisis of non-communicable disease requires some strategic redesign of the array of sub-systems that Mexicans have inherited from earlier generations. In particular, continuity of insurance affiliation is important because a large percentage of Mexicans switch between schemes during the course of a year if their employment status changes, which will affect continuity of care. Many of these individuals may prefer to maintain affiliation with their insurer if given the choice to do so. Continuity of care would also promote quality and efficiency, and enable more sustained engagement in individuals' personalised preventive care.

A number of steps need to be taken so that individuals are able to *maintain insurance affiliation after a change in employment*. Currently, workers are allowed to continue with SS benefits for two months if they become unemployed. In the short term, general tax revenues could subsidise insurance contributions for formal workers who change employment but wish to remain with their health insurer and who are otherwise unable to afford their household insurance premium. Although this may appear to be a risky strategy, it should be borne in mind that formalisation of the Mexican workforce appears to be happening rapidly – an encouraging context for this type of reform. Nevertheless, effective legislation to prevent companies from transferring employees to sub-contracted, or informally-employed, arrangements will be necessary. Mexico's SS institutes have made significant auditing efforts in recent years to eliminate illegal practices of this nature, and these should be extended. It may also be sensible to pilot a reform of this nature in a few areas, with close monitoring of SP and SS affiliation rates, and rates of formal and informal employment.

In the longer term, to support greater portability of insurer, efforts are needed to equalise the benefits package, quality of care and prices of services across sub-systems. Again, an incremental approach is advisable and should start with selected services where quality and price can be easily standardised. Immediately apparent, easily defined, examples include discrete interventions, such as elective surgery or maternity care. It would also make sense to standardise care and prices for high-cost services, such as renal dialysis, or care for HIV. But primary and preventive care should not be forgotten. In particular, Mexico should look to the extensive international experience that exists in defining and pricing packages of care for chronic diseases such as diabetes. Service delivery contracts

for groups of patients with diabetes and other public-health priority conditions could then be exchanged across sub-systems.

Another important but currently politically difficult step would be to *delink health insurance from other functions of social security institutes* so that health insurance schemes exist as their own entities. This is necessary so that individuals can maintain their health insurance affiliation without necessarily continuing to finance or participate in other functions of social security institutes, such as pensions and other social security benefits. The adverse circumstances challenging the financial sustainability of the social security institutes are well known. This may provoke significant restructuring, especially if support from public funds is needed. As a condition of this, it would be prudent to require the social security institutes to split health insurance from their other functions. In the short term, this would facilitate maintenance of insurer affiliation among people who change employment status, because it would be less costly to contribute to just the health insurance portion of a social security institution, than to contribute towards all functions.

Similarly, to promote continuity of care and enable Mexicans to shift more easily between insurers, *user health records should be easily transferable* and accessible among providers regardless of scheme affiliation. Wider access to user information can also make other administrative barriers to unifying the system less complicated in the future. Currently, IMSS and ISSSTE facilities do not need to be accredited by law, although private facilities must be accredited for *Seguro Popular* to contract with them. In the future, accreditation mechanisms should consider health outcome measures, rather than purely infrastructure-related indicators of quality. Better resource allocation and improved financing mechanisms could also be useful for improving and homogenising quality, and for ensuring that scheme resources adequately reflect enrolee health needs.

It would also be desirable to *agree on national level prices and engage in more bulk purchasing* of services, rather than case-by-case contracting. Public-private partnerships might be another good way to improve infrastructure planning while also encouraging portability of care. For example, private funding could be used to construct a public facility where some portion of the building is dedicated for public services and another portion is private (possibly contracting with the public sector). Lastly, better information for patients is important so individuals are aware when they have the right to see a provider outside their network.

Reconfiguring financial flows across schemes would lead to improvements in both revenue collection and resource allocation

In many OECD countries, health system revenues are pooled or redistributed at national level. The motivations for doing so include promotion of social solidarity, improving equity and enhancing system efficiency. Pooled financing makes it easier to allocate resources commensurate with need and may protect individuals and insurers against financial loss by spreading risk across larger populations. A more unified approach to financing is of particular urgency in Mexico given that large numbers of individuals transfer between IMSS and *Seguro Popular*, and vice versa, each year due to changes in employment status, which disrupts continuity of care. Some degree of shared funds that all schemes could draw on for carefully selected services would enable care to be more easily transferrable across insurers and potentially lead to efficiency gains.

The challenge is to redistribute funds and services in a way that delivers system benefits whilst being politically acceptable. Important differences in opinion on how to do this exist in Mexico. Wider pooling already exists for the Fund for Protection against Catastrophic

Expenses (*Fondo de Protección contra Gastos Catastróficos*). Part of *Seguro Popular*, this operates as a single fund, and is a potential model for other types of care. It may be feasible, for example, to create *a national pool to pay for rare high-cost diseases or specialised medicines.* Likewise, a single fund for prevention should be considered. Currently there are 36 national prevention programmes financed by vertical budgets based on historical precedents. If there were a single unified fund earmarked for prevention, resource allocations could be more easily adjusted to reflect needs in specific prevention areas.

Other steps toward aligning funding and activity across the sub-systems are feasible in the short term. The legal framework to allow SP and SS to use each other's services exists, through agreements known as *convenios.* These agreements have been used sparingly, however, and have mainly taken the form of social security institutes purchasing services from SP in order to alleviate capacity constraints (particularly in the case of diagnostic tests, such as laboratory studies and X-rays) – rarely the other way around. Further opportunities to *expand the application of convenios, at both state and national level*, should be sought – in ways that promote the accessibility and continuity of care for individuals with chronic diseases in particular. Extending the use of *convenios* to new areas such as maternity care or care for diabetes would be functionally equivalent to allowing Mexicans to maintain insurance plan after a change in employment status as discussed earlier, and would be an important step towards this longer-term policy ambition.

Other steps include *establishing a standing forum, or commission, to represent all SS and SP health insurance funds.* This forum would offer a shared resource to support SP and SS institutes to move towards interoperable information systems, streamline administrative costs, identify interventions where quality and price can be easily standardised to enable exchange of services, and work towards implementing a shared quality monitoring and improvement agenda, amongst other priorities.

There are substantial opportunities to improve the health system information infrastructure in Mexico. According to the Ministry of Health, 15 information systems were designed as part of *Seguro Popular*. Yet according to some states, good data is not available to help them run local SP programmes effectively. One clear benefit of homogenising the schemes would be to streamline data collection and *work towards consolidated, interoperable databases of health system information*. A simpler, more efficient data collection system would reduce time spent filling out paper work and ensure that there are not several systems collecting duplicate information. A better integrated health information system could also be used to ensure that the Ministry of Finance is not paying contributions to multiple schemes for some enrolees. To this end, *IMSS Digital* is an important step to improve electronic health records within IMSS. However it is not clear whether this will create even more fragmentation if this system is designed to be parallel rather than eventually integrated with the other schemes.

Smarter purchasing of goods and services

Finally, attention should also be focused on how goods and services are purchased in the Mexican health system. The lack of separation between the purchaser and provider roles has hampered the development of a set of incentives capable of spurring quality and efficiency. Effective separation of these functions should be a priority therefore. This would lay the foundations for wider use of selective contracting, user choice and more innovation at the provider level. Greater flexibility in the contracting and performance management of health care workers is also needed.

Current reimbursement arrangements for providers offer weak incentives for efficiency and quality

With no real separation between the purchaser and provider roles in the Mexican health system, it has become difficult for insurers to develop a system of incentives to foster efficiency, productivity and better care quality. Hence, one priority to enhance health system performance must be a progressive shift toward a *clear separation of purchaser and provider functions*, as is already established in many OECD health systems.

Payment systems for providers have also largely remained unchanged over recent years, despite significant reforms in other areas. Hospitals in the SP and SS sub-systems are mainly paid through retrospective budgets, whereas per-diem payment is used in many private hospitals. There is accumulated evidence from reforms in OECD countries and elsewhere suggesting that payment arrangements based on historical activity or volume give hospitals little financial incentive to improve efficiency or the quality of services.

Payment methods for medical professionals are also weakly geared to quality and productivity. In the public sector these are salaried professionals hired on national contracts negotiated collectively by the unions, with rigid conditions governing salaries, working hours and social security benefits. Although there is widespread recognition of the benefits of moving towards more flexible contractual arrangements and payment based on performance, collective agreements have prevented modernisation of the incentive system.

A purchaser-provider split should be introduced gradually but decisively

The majority of OECD member countries assign responsibility for the purchasing of health care goods and services to some regional level organisations, usually regional governments or health funds with regional affiliations. Although there is a fair amount of variation in approaches depending on national context, a common feature across these national experiences has been the gradual implementation of the purchaser-provider split in the system, as opposed to a "big-bang" strategy, generally with positive results for the health system.

Within the SS institutes, *separation of the purchaser and provider functions should be clearly realised*. Internally, within each SS institute, the purchaser-side should demand increasing refined information on activities, costs and outcomes from the provider-side. This will lay the foundations for transparent, intelligent purchasing. Similarly, within SP, the role of the REPSS (*Regímenes Estatales de Protección Social en Salud*, or the representatives of SP within Mexico's 32 federal entities) as *regional purchasers of SP health services should be strengthened*. The basic legal framework for REPSS to evolve into fully-fledged purchasing agencies is already in place. REPSS offices can in principle obtain the status of *organismo público descentralizado* (OPD), making them independent legal entities with greater operational autonomy. In states with weaker administrative capabilities, REPSS could be allowed to operate as "functional" OPD with support given by the Ministry of Health, similar in spirit to the situation of IMSS regional offices that, for some time, have been purchasing various services from SP providers. Such agreement frameworks would allow REPSS – as well as social security institutes – to purchase services strategically from providers working with more than one insurer, thus optimising access, efficiency and quality.

Ultimately, in the longer term, this would also open the possibility of provider competition for users in Mexico, which has been applied in other contexts alongside selective contracting. Such arrangements are associated with positive effects on system

efficiency and quality of care – on the condition that providers must compete to attract users based on aspects of service quality and not price. As the Mexican system moves towards the *introduction of selective contracting mechanisms and provider competition*, it should move away from soft budgeting mechanisms for purchasers and retrospective reimbursement of providers. These tend to reduce incentives for purchasers to push for lower prices from providers and allow providers to compensate for lower prices by raising the volume of (unnecessary) services delivered.

Stronger focus on leadership, oversight and stewardship by the Ministry of Health will be needed to support a purchaser-provider split

As regional offices become more confident at contracting services, the role of the Ministry could evolve to focus on strategic oversight, co-ordination and regulation. On the provider side, the process of augmenting local autonomy would need to be undertaken in incremental steps, and will depend on robust performance management. It could start with *transformation of selected hospitals into prospectively-funded organisations*, where managers are given some autonomy for day-to-day decisions (say mainly financial management) under agreed performance targets monitored by the payer (REPSS, for instance). This system could evolve later towards a model of corporatised organisations with greater autonomy but where hospitals keep their public status, similar to the Foundation Trusts created in the United Kingdom, or public hospitals operating as state-owned enterprises in other health systems.

Efficiency gains around service provision are more likely to appear where the contracting process is linked to planning. It is important for a *national strategic health plan*, ideally drawn up by the Ministry of Health in consultation with the SS institutes and other stakeholders, to define areas of action within a specific timeframe, and for these priorities to become the general framework for the strategic health plans set out by REPSS and other purchasers. This should in turn define the priorities for service delivery at local level, through responsive contracting with providers.

Linking contracting to national and local priorities requires strong leadership by the Ministry of Health, to provide general guidance to the states and create a legal architecture to mandate purchasers to develop strategic purchasing plans during a given period of time. These purchasing plans should signal to providers national and local health care priorities and estimated needs, as well as the corresponding plans to meet such needs (budgetary allocations, quality standards and so on). In France, regional strategic health planning is influenced by national planning and defines the goals for hospital care provision over a five-year period and appears to be a successful model of local autonomy and central steering.

The Ministry of Health should co-operate closely with other governmental oversight institutions such as *Secretaría de la Función Pública* (Ministry of Public Administration) in their efforts to *increase managerial transparency and accountability at the level of states and municipalities*, including through the promotion of an integrated information system allowing regular collection and auditing of information about institutional purchases and spending.

More emphasis should be given to prospective reimbursement in the hospital sector

Paying hospitals through historical budgets gives facilities no incentive to seek efficiency gains or improve quality of care. The purchaser-provider split and strengthening

of purchasing agencies discussed above would open the door for selective contracting and the development of prospective payment methods that are better suited to improve provider performance. IMSS has developed a diagnosis-related group (DRG) system based on information about service costs and clinical pathways. Moreover, a few local IMSS offices have introduced incipient fee-for-service payment mechanisms and are looking into alternatives to pay hospitals based on performance indicators.

The implementation of DRG systems has promoted hospital efficiency without lowering quality of care in many OECD member countries, but a unified approach is necessary to introduce a similar mechanism at the whole system level. An initial step for the creation of a DRG system in Mexico would be to ensure that the coding of diagnoses and procedures across insurers and their providers is harmonised and closely follows widely accepted norms (such as the WHO ICD-10 system already in use). This also requires strengthening and integrating the different hospital information systems in the various provider networks, to ensure interoperability as far as possible. Costing of a common package of services to be offered across all providers, with clearly defined clinical pathways and minimum inputs, will then be possible.

Depending on the anticipated scale of fee-for-service reimbursement, vis-à-vis prospective financing, it will be crucial to put mechanisms in place capable of preventing the substantial cost-escalation experienced in some health systems. Since sophisticated risk-adjusted payment arrangements (and political consensus around them) take time to be developed, a first step could be to introduce a global health spending cap to control growth in costs due to cost-per-case payment in the short run, with ceilings on volume of services reimbursed and possibly sanctions for above-average costs. Eventually, as know-how and instruments to monitor contracts develop, the Ministry of Health would have a key role to spur periodic negotiations and formal revisions of a nationally-binding fee schedule with stakeholders to reflect changing economic conditions, as it is done in Japan.

A gradual transition to prospective reimbursement does not require the complete abolishment of retrospective payments in the hospital sector. In fact, the Mexican system could benefit from maintaining a complementary retrospective, cost-per-case reimbursement component for some services. This could apply, for instance, to particularly expensive treatments or as an interim arrangement for the reimbursement of cases treated by providers still in the process of establishing a contractual agreement with purchasers. In this sense, retrospective reimbursement could support broader portability of services in Mexico by facilitating compensatory payments between purchasers when users are treated outside the geographical area covered by their insurer (as currently the case in countries like Sweden).

There are also gains to be made in how pharmaceuticals and other goods are purchased and distributed

Reforming purchasing methods should be another priority in the Mexican health system. Significant savings have already been realised through consolidated purchasing of pharmaceuticals. The *Comisión Coordinadora para la Negociación de Precios de Medicamentos y otros Insumos para la Salud* (CCNPMIS, the Coordinating Commission for the Negotiation of Prices of Pharmaceuticals and other Health Inputs) has helped standardise the prices paid for patented or single-source drugs by SP and the SS institutes. Analyses suggest savings of around USD 65 million per year as a result, accruing largely to IMSS (42%) and the Ministry of Health (33%). In light of such savings, the federal government rightly intends to expand the scope of its joint drug purchasing policy to most medicines and medical devices.

Tender processes for contracts with the federal government should involve a larger number of states and could gradually move away from its current "all or nothing" format towards allowing smaller producers (who often do not have the capacity to supply the full quantities required by a huge, unified market) to bid for part of the supply contracts. This would bring more pharmaceutical companies into the negotiations and likely drive purchasing prices further down – with potential savings also for those drugs that are purchased in smaller quantities and at higher prices.

There is also scope for reductions in drug distribution costs within Mexican States through a wider – and carefully regulated – *participation of the private sector as a distribution network*. This approach has been successful in improving access to pharmaceuticals in many health systems with some degree of decentralisation, including the Nordic countries and the United Kingdom. Appropriate regulation will be necessary. The Ministry of Health must devise clear rules for such participation in the distribution network, including minimum required standards of service quality and probity (such as opening hours, staffing levels, conflicts of interest over sales, and so on). It must also implement effective internal processes to gather data and monitor prescription patterns across pharmacies, with explicit provisions to ensure that clinical protocols are adhered to.

Management of the health care workforce should also reward productivity and quality

Most of Mexico's doctors continue to be paid salaries or fees-for-service. One of the major challenges holding back innovation in new physician payment strategies is the current legal framework governing labour conditions. It is crucial for the federal authorities to seek negotiations with the unions to enact legislative reforms that enable a *shift away from the inflexible hiring conditions of health personnel, and away from salary arrangements* as the sole reimbursement mechanism for physicians working in public institutes. More flexible hiring conditions regarding payment and working hours would be crucial also to give SHS increased ability to attract primary care and specialist doctors to underserved areas, normally rural settings.

Part of the *IMSS-Prospera* workforce is already hired on more flexible contracts. Also, a few states such as Nuevo León have taken advantage of the possibility of using temporary contracts to hire some specialist doctors paid on a fee-for-service basis, with contract renewal dependent on doctors meeting pre-defined quality standards. Extending this possibility to SP/SHS and social security institutes in general is fundamental to allow the development of physician payment methods that stimulate good performance.

Movements away from salary payments for primary care doctors in Mexico do not need to be wholesale changes. In fact, there are strong arguments in favour of mixed systems involving salaries, capitated and fee-for-service payments for primary care physicians. A clear example in the current Mexican context is preventive care and community-targeted public health. In this area, capitated payment methods for general doctors mixed with fee-for-service for specific interventions (such as immunisation or prenatal care), coupled with elements of payment linked to performance targets in chronic disease management and health promotion (concerning the share of patients with diabetes adequately controlled, for example), have been successfully applied in many other country settings. In the United Kingdom, for instance, performance-based contracts for primary care clinics (the *Quality and Outcomes Framework*) included targets related to advice and support for smoking cessation for patients in treatment for diabetes and heart disease.

The introduction of *performance-related incentives into the remuneration of health professionals* should also be considered. As well as supporting quality and efficiency, these incentives may also help mitigate concerns about other issues. There is a general perception, for example, that Mexican health workers are relatively low paid, so some supplementary performance-related component could increase average wages. Secondly, the existing gap between physician salaries in the private and public sectors is one of the reasons why dual public/private practice is extensive in the Mexican context (although doctors may also have other professional motivations for pursuing private practice). However, private medical practice remains largely unregulated, and so does the mix between private and public incomes and working hours for physicians.

Finally, as a complement to the initiatives above, it is necessary to implement *clearer rules for the largely unregulated private medical practice*, avoiding subsidisation of private activities and possibly establishing a transparent fee schedule for such use of public infrastructure in some cases. Clear rules for dual practice and private practice in public facilities are needed, particularly for doctors working in hospitals. Regulations could include allowing physicians to treat private patients in public facilities and be paid for these patients on a fee-for-service basis, with a share of the fees going to the facility to pay for any public services provided as part of the treatment, as implemented among others in Austria, Germany and Ireland.

Box 0.2. Recommended reforms to Mexico's health system

In the face of unprecedented health system challenges, Mexico must ensure that it can offer all citizens equitable, efficient, sustainable and high quality health care. To do so, it must move to a health system that is centred on people's needs, rather than one that is rigidly constrained by historical institutional arrangements. The health system must renew its focus on prevention and strengthen primary care; consolidate and expand the revenue base for health care; and improve contracting and purchasing arrangements in ways that optimise access, quality and efficiency.

1. A renewed vision for health care in Mexico, focused on people-centred high-quality care, must be articulated across the health system by:

1.1. Coupling the political momentum of current debates on reforms to the Ley General de Salud with the framework of people-centred health care to build consensus on the need to evolve the health system from a set of rigidly independent sub-systems, to one that is responsive to the changing needs of individuals and communities across the life course.

1.2. Putting quality monitoring and improvement at the heart of health system governance:

- A comprehensive strategy on quality would include strengthening arrangements for professional licensing, continuing professional education, accrediting health care facilities, developing national standards and guidelines and publishing national audits of the quality of care.

- Plans to create a new national agency to encourage quality improvement activities at all levels of the health system should be accelerated. This body, fully independent of the Ministry of Health and SS institutes, should develop key activities such as setting minimum quality standards; developing national guidelines for care; collecting and analysing quality and outcomes data; and supporting or sanctioning poor performers.

- Mexico's private hospitals and clinics must be fully involved in any initiatives to improve access, quality and efficiency. This should include pharmacies offering medical consultations on their premises.

Box 0.2. Recommended reforms to Mexico's health system *(cont.)*

1.3. Building a data-driven health system:

- A strategic review of information systems should address how Mexico can move from its current fragmented set of information systems to a nationally consolidated approach focused continuous quality improvement, personalising care and ensuring continuity, and supporting contracting and purchasing through clearer accountability for results.
- A national, consolidated patient register, or its functional equivalent,should be implemented by working towards the integration of SP registers of affiliates with those of social security institutes. Once the essential minimum of a national patient register is established, the focus should then be on consolidation and interoperability of the various additional databases used by SP and the SS institutes.
- A system-wide, independent regulator for data who can oversee the expansion of electronic health records should be established. It will also be crucial to ensure that the legal framework around data privacy supports record sharing whilst affording adequate safeguards.
- A set of nationally applicable performance indicators should be agreed, applied uniformly across all providers and published regularly. These should be linked to national standards and guidelines for care. Indicators that can be constructed from already routinely collected data, such as waiting time for a doctor appointment and user satisfaction, should be developed first.

2. All Mexicans, irrespective of employment or social position, should have access to a commonly-defined, equal benefits package centred on strong primary care by:

2.1. Taking steps to develop a more equal benefit package across insurers:

- a more robust and independent system for health technology assessment and cost-effectiveness analyses is needed. Establishing CENETEC as an independent arm's-length body (*organismo público decentralizado*) should be considered.
- the social security institutes should consider more explicitly defining their benefits package, as is common practice across OECD social security institutes. Secondary private health insurance may have a role for services at the margin.
- an equal benefit package across insurers could start with by defining entitlements around high-cost diseases, such as HIV.
- Primary and preventive care should not be forgotten and Mexico should follow international experience in defining and costing packages of care for chronic diseases such as diabetes. This would have the advantage of raising the profile of preventive and primary care, and offer an opportunity to set out patients' responsibilities and obligations, as well as their entitlements.
- policies around co-payments should be revised to ensure that, if used at all, they are carefully targeted to low-value activities/treatments and high-income groups.

2.2. Strengthening preventive and primary care:

- Mexico should seek to develop primary care as a distinct speciality, with effective management of long-term conditions as a core activity. New primary care specialists should be unambiguously distinct from current community generalists, based upon extended knowledge, skills, roles and responsibilities, and underpinned by clear licensing criteria.
- Mexico should rioritise provision of continuous care for those with multiple, complex health care needs, including long-term conditions such as diabetes, should be prioritised as a key function for the new speciality.

Box 0.2. Recommended reforms to Mexico's health system *(cont.)*

- The full set of skills within the primary and community care workforce should be used to deliver preventive and primary care, including nurses and community pharmacists. In particular, Mexico has far fewer nurses than other OECD countries - more primary care nurses urgently need to be trained.
- The primary care information infrastructure must be developed, in order to build a richer picture of the effectiveness, safety and patient centredness of care in this sector. In the longer term, information on cost and quality should be used to incentivise individual providers' improvement, through benchmarking or pay-for-performance schemes.
- Mexico should consider introduction of a system to allow all patients to formally register with a named primary care specialist across all SP and SS provider networks. This would support continuous, co-ordinated care as well as allow calculation of quality indicators for specific patient groups (e.g. rate of adequate glycaemic control amongst diabetics).

3. Mexico should take steps to unify its fragmented health financing approach in an effort to improve efficiency and equity of access:

3.1. Mexico should increase its level of public expenditure on health to align more closely with those of other OECD countries, alongside initiatives to increase health system efficiency:

- Efforts are needed to increase the size of the formal labour force to generate additional revenues for the health sector.
- High out-of-pocket spending can be avoided by improving access to public sector care, for example, by investing in longer working hours in public facilities.
- A gradual shift towards increased financing from general tax revenues, particularly for new revenues would improve the predictability of funding, whilst keeping pay-roll contributions as the major source of SS funding in the short to medium term.

3.2. Seguro Popular's resources should be distributed more regularly to states and allocations should be based on need rather than the number of enrolees:

- States must receive federal funds on time so that they are able to plan accordingly.
- Incorporating need-based indicators into a resource allocation formula should be done, but with caution so as not to exacerbate existing inequalities.
- Improvements in financial reporting by states could be rewarded with additional funding, or withheld funding if the quality of states' data does not allow effective performance monitoring.

3.3. Mexicans should be able to maintain health insurer coverage, regardless of their employment status:

- Decoupling health insurance from the other functions of social security institutes should be considered, to enable individuals to more easily maintain their health insurance plan after a change in employment status.
- Unique user identification numbers (based upon the Clave Única de Registro de Población), standardised communication templates and a integrated database for all Mexican health records would help to facilitate portability of scheme affiliation and continuity of care.

3.4. While a single pooled fund, or its functional equivalent, is unrealistic in the short term, a number of steps toward aligning funding and activity across the sub-systems could be taken:

- Unified national pools to pay for rare high-cost diseases, specialised medicines or preventive health care activities should be considered.

Box 0.2. Recommended reforms to Mexico's health system *(cont.)*

- Application of *convenios* between SP and SS should be expanded, at both state and national level, in ways that promote the accessibility and continuity of care for individuals with chronic diseases in particular.
- A standing commission should be created to better co-ordinate the sub-systems, to support SP and SS to move towards interoperable information systems, and identify interventions where quality and price can be easily standardised to enable exchange of services across sub-systems.

4. Mexico should refocus health system priorities to include also the performance of health care services concerning efficiency and quality:

4.1. Implementing an effective separation of purchaser and provider functions:

- The roles of purchaser and provider need to be separated decisively within SS institutes, at the same time as strengthening the role of REPSS offices as purchasers of health services through their transformation into *organismos públicos descentralizados*.
- Purchasers and providers should gradually be given increased managerial and financial autonomy to seek performance gains. This could start by granting REPSS more decision rights regarding procurement and service delivery, which should be accompanied by a clear national plan setting out strategic health system priorities.
- The roles of the Ministry of Health in terms of co-ordination, regulation and oversight should be strengthened. National authorities should have oversight of insurers' strategic purchasing plans, and approve them if they are in line with the overall system strategy.
- The Ministry of Health should co-operate closely with other governmental oversight institutions such as *Secretaría de la Función Pública* (Ministry of Public Administration) to support capacity and accountability at the level of states and municipalities.

4.2. Reforming current purchasing methods:

- Prospective case-based reimbursement mechanisms should be favoured in the hospital sector instead of the current emphasis on retrospective budgets. This could be combined with fee-for-service payments for some hospital services where appropriate, as well as global spending caps to avoid cost escalation.
- The federal government should lead negotiations for an agreement on prices for a common package of services to be offered by all SP and SS health care providers. This approach could start with a few easily standardised and priced interventions – gradually expanded over time. An initial focus on preventive and primary care would be advantageous, including chronic conditions such as diabetes where there are international precedents for clearly defined and priced packages of care.
- The mechanism of consolidated drug purchasing should be expanded to involve further states, more pharmaceutical companies and products. Lowest-price bidding should be allowed for some contracts.
- The costs of drug distribution should be explicitly incorporated into the negotiated contracts, and could be reduced by allowing the participation of the private sector as a distribution network.

4.3. Reforming contracting and working conditions for health professionals:

- A negotiation process with trade unions should be pursued around legal reforms to make hiring and working conditions of health personnel more flexible.
- Remuneration mechanisms for physicians should reduce their dependence on salaries and move towards a mix with capitation as well as fee-for-service payments for specific services, particularly in primary care.
- State level purchasers should be given more flexibility as to how federal transfers earmarked for staff financing are used, including the possibility to devise performance-related payment strategies for providers.
- A transparent fee-schedule for private services provided within public institutions and clearer regulation about dual medical practice in the public and private sectors should be introduced.

Note

1. This is the OOP estimate reported by the Mexican authorities to the OECD. OOP spending can be estimated from a variety of sources. Although these are not always in agreement, it is clear that OOP spending in Mexico remains amongst the highest in the OECD.

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MEXICO

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