Chapter 7

Health Policy

Francesca Colombo, Ian Forde, Ankit Kumar,
Valérie Paris and Franco Sassi

Mexico has made significant progress in the health sector over the past few years. Through its innovative programme *Seguro Popular*, Mexico has virtually attained universal coverage for the population, bringing it in line with most other OECD countries. However, despite dramatic improvements in life expectancy and infant mortality, it remains below the OECD average on basic indicators of health status. While health expenditure has grown fast in the past decade, it remains much below other OECD countries. More importantly the level of public spending is particularly low and out-of-pocket payments are very high. The health system is also fragmented, leading to wasteful spending, and access to health care still varies considerably across states. Improving the country's health services will require addressing the problems of the poorer states, targeting services where they can deliver the highest value for money, and improving the efficiency of health delivery. These changes will help Mexico deliver on the commitment contained in the 2012 Pact for Mexico to equalise quality and coverage across different health coverage schemes. This aspiration should guide further reforms to expand access to care services, with policy guided by the development of targets including the services covered and the actual utilization of services by different socio-economic groups and across regions.

Mexico has seen dramatic improvements in life expectancy and a steady reduction in infant mortality rates over the past decades. Life expectancy has increased by 19 years since 1960, reaching 75 years in 2010, while infant mortality has been reduced to a fifth of the 1970 rate thanks notably to *Oportunidades* (see Chapter 2). However, life expectancy remains the fifth lowest in the OECD and premature mortality is the highest in the OECD. Mexico has a comparatively low supply of inputs to the health care sector – beds and doctors – by OECD standards.

Mexico has already implemented an ambitious reform. Over a spectacularly short period of eight years, the *Seguro Popular* has succeeded in bringing universal coverage to half of the population which remained uninsured. Mexico's path to achieving universal coverage of its population is remarkable in many respects including low fiscal costs and the financing mechanism that contributes to narrow inequality in the allocations of federal finance across the States.

Despite this success, several challenges remain. Mexico still spends considerably less on health than other OECD countries. While total per capita spending on health is near what might be expected given the level of income, the Mexican health sector is characterised by a relatively low level of public expenditure and significant out-of-pocket spending. This suggests that the system falls short of providing adequate insurance coverage. Improved efficiency in service delivery and better administrative capacity, particularly at state level, will be important to ensure the continued success of reforms over the longer term. In addition, emerging health threats such as obesity and the more generally the increasing burden associated with chronic diseases need to be addressed. The organisation of the system is characterised by different vertically integrated silos, each serving different segments of the population and with little interconnection between them. This has led to significant inequalities in the provision of health services across regions and fragmentation which has to be addressed.

Using innovation to provide affordable coverage

The *Seguro Popular* has been one of the most innovative policy examples of how to enrol the poorest households and those working in the informal sector. Over a period of eight years since 2004, Mexico has reached over 50 million people

that were previously lacking access to social security, with users reporting 97% satisfaction rates.[1]

This has been a tremendous success. The *Seguro Popular* is regarded worldwide as an example of innovation in health coverage (Knaul *et al.*, 2012; OECD, 2005), from two main perspectives. First, it is built on incentives for state and individuals to enrol into the programme, without formally establishing a mandate to coverage. By directing the additional funding of the scheme to the States on the basis of the number of new enrolees, it introduced a mechanism that allocates more resources to poorer states, which possessed the greatest number of uninsured individuals. Second, *Seguro Popular* was carefully designed to achieve universal coverage at relatively low fiscal cost. It covers treatments for a limited range of diseases, without undermining the system's fiscal sustainability. By specifying explicit entitlements, the government has hence been able to channel expansion in the most cost-effective areas: the essential primary and hospital care services.

In addition, *Seguro Popular* does not seem to have increased incentives for informal work by reducing the relative benefits of the current contributory system (see Chapter 5 and OECD [2011b]).

The challenges of improving financial protection and addressing funding gaps

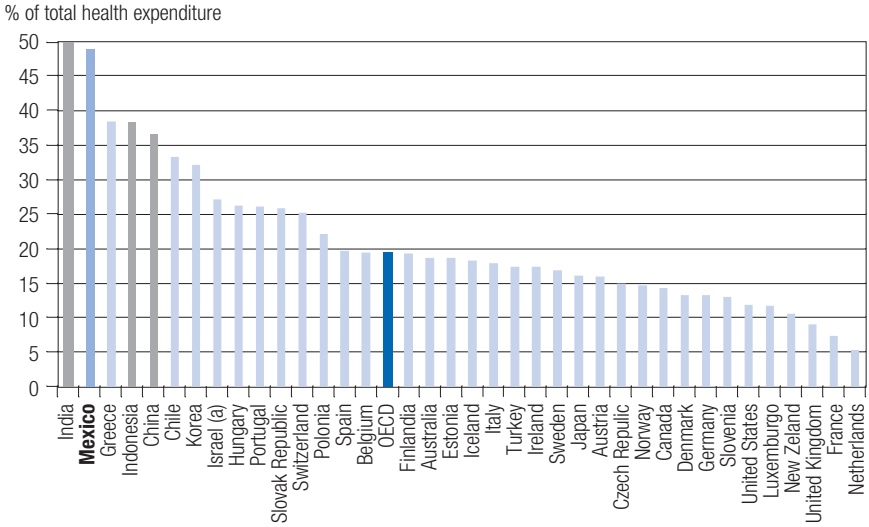
Despite Mexico's widely heralded success at extending health insurance to previously uninsured populations, a number of challenges persist. The main one is to improve access to care by expanding the range of services covered by the *Seguro Popular*, making it easier to access services across all States and in rural areas, improving the quality of health care services, and addressing the rising burden of chronic diseases. To do this, Mexico needs to make incremental reforms in three main areas: financial protection, the range of benefits offered by *Seguro Popular* and availability of financing.

Improving financial protection

Mexicans are still exposed to disproportionately high out-of-pocket costs for their health care. Out-of-pocket payments remain the highest among OECD countries, and second only to India when emerging economies are included, as shown in Figure 7.1. The share of health care expenditure financed out-of-pocket has dropped only marginally, from 51% in 2000 to 49% in 2010. In per capita terms, out of pocket spending grew by 24% in real terms between 2000 and 2010. This level of out-of-pocket payments is higher than in countries with similar level of

[1] *http://www.seguro-popular.salud.gob.mx.*

Figure 7.1. **Out of pocket payments as a percentage of total health expenditure, 2010**



a. Information on data for Israel: *http://dx.doi.org/10.1787/888932315602*.

Note: non OECD emerging economies in this Figure are: Indonesia, China and India.

Source: *WHO Global Health Expenditure* database; OECD Health Data 2012

income per capita[2], such as Chile, Turkey, Estonia and Hungary, and well above the OECD average of around 20% in 2010. It reflects inequalities in coverage across population groups.

The reduction of out-of-pocket payments has not been as rapid as in other countries that have been expanding health coverage, such as Turkey and Korea. The persistence of such high out-of-pocket expenditure at a time of rapid expansion of health coverage suggests that families are still faced with difficulties to access the services they need, or continue to spend more to access perceived higher-quality services in the private sector, where there is markedly less insurance cover. This also leads to persistent differences in access between those covered by the *Seguro Popular* and those affiliated to Social Security. For example, while outpatient consultations and use of hospital services have improved over time for those previously uninsured, rates of utilisation are still higher amongst social security beneficiaries, with consultations of general physician at 17.8 in 2010, compared to 11.1 for those not enrolled in social security (Knaul *et al.*, 2012). Therefore, the government ought to continue efforts to reduce out-of-pocket

[2] Adjusted for differences in price levels across countries.

spending by encouraging States to locate health care facilities and staff closer to the poor and by expanding the range of benefits covered.

Expanding the range of benefits covered under the Seguro Popular

The *Seguro Popular*'s positive inclusion list has successfully contained health expenditure while health coverage expanded. The entitlement to a package of essential services helped to direct funding to the most cost-effective services. The benefit services covered in the package has continued to expand over the years, from 91 interventions in 2004 to 284 in 2012. This covers more than 95% of cases in ambulatory units and general hospitals (Knaul *et al.*, 2012).

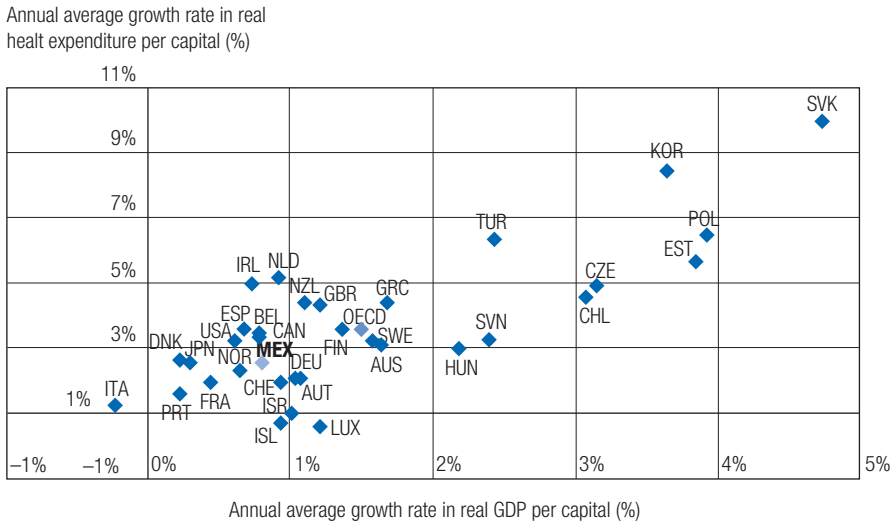
The forthcoming challenge will be to ensure that the services offered under the *Seguro Popular* meet the health needs of the population. The *Seguro Popular*'s list of coverage for catastrophic health expenditures (the *Fondo de Protección contra Gastos Catastróficos*) is more limited than that offered under the package of essential services.[3] The coverage for catastrophic health expenditures includes cancers (mainly childhood cancers, with few adult cancers covered apart from breast, cervical, uterine, lymphoma and testicular tumours), transplants, some complex surgical procedures, neonatal care and HIV/AIDS. It also includes care after a heart attack, but only if the patient is under 60 years old. There is no coverage for older patients, or for the catastrophic expenses that may arise from non-communicable diseases such as stroke or the need for renal transplant or dialysis. This is likely to become more of a concern as chronic diseases such as diabetes continue to rise amongst the Mexican population. Additionally, while the benefits offered by the *Seguro Popular* in public outpatient clinics and general hospitals are very similar to those provided by comparable services in social security agencies, those belonging to the social security sector have access to a significantly broader number of acute care procedures.

Addressing funding gaps

To permit these expansions and ensure real improvement in health services, extra financing needs to be found. Health expenditure is not out of range from what could be expected given Mexico's income per capita. Nonetheless, despite the substantial fiscal commitment accompanying recent reforms, at 6.2% of GDP, Mexico's health expenditure remains modest compared to OECD countries (the OECD average being 9.5%) – the second lowest in the OECD after Turkey (6.1%). Relative to economic growth, health spending has risen faster than in France,

[3] The insurance scheme includes a package of essential services and a package covering catastrophic health expenditure (e.g. expenditure for health care that threatens the household's capacity to finance basic needs), financed through the Fund for Protection against Catastrophic Health Expenditures *(the Fondo de Protección contra Gastos Catastróficos)*.

Figure 7.2. **Average growth rate in real health expenditure per capita 2000-2010 (or nearest year)**



Source: *OECD Health at A Glance*, 2012.

Germany or Portugal. However, it has also not been growing as fast as in Korea, Estonia and Turkey, countries that have similarly pursued major expansions in coverage (or in their benefit package) (Figure 7.2).

Slower growth in health spending may reflect lower utilisation of more expensive health services or the lesser needs of a younger population. But to ensure good access to care, an adequate supply of drugs is needed (see below). In addition, like in almost all other OECD countries, Mexicans will be living longer with a chronic condition. This transition of the health burden from communicable to chronic diseases will require some increases in health spending levels. It will place greater demands on physician and medical resources than communicable diseases, because chronic diseases will require relatively more expensive treatments for people living over an extended period of time. The magnitude of this challenge is illustrated by the fact that Mexico has the second highest obesity rate in OECD countries and the highest diabetes prevalence in the OECD.

Tackling emerging health challenges

Obesity and diabetes which affect an increasingly large proportion of the population are becoming major challenges for the Mexican health care system. Over the past 30 years, Mexico has become one of the countries in the world most heavily affected by the global epidemic of obesity. It ranks behind the

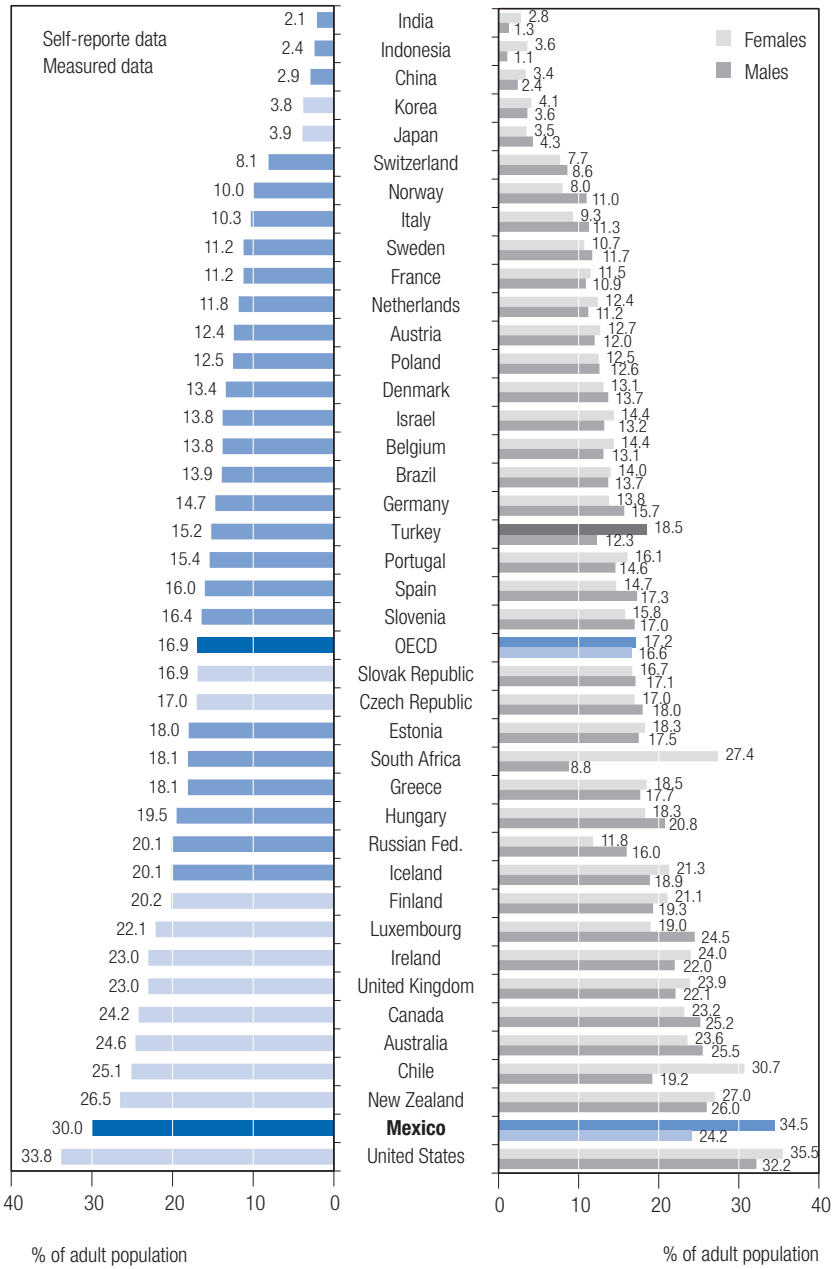
United States as the second fattest nation in the OECD (Figure 7.3). Between 2000 and 2006, overweight prevalence increased from 62.3% to 69.5% of the adult population, while the rate of obesity rose from 24.2% to 30%. In addition, Mexico is among the countries with the highest child obesity rates in the world with one in three children overweight or obese.

Diabetes, the chronic disease most directly linked with obesity, is also spreading rapidly. An estimated 10.8% of Mexicans aged between 20 and 79 has diabetes, one of the highest rates in the OECD. Type 1 diabetes – the predominant form of the disease in younger age groups – accounts for 10-15% of all cases.

OECD studies show that one of the most effective policies for preventing obesity and diabetes-related diseases is to provide counselling in primary care for at-risk adults. The OECD has developed a microsimulation model which allows countries to assess the best policies to tackle obesity and the diseases to which it contributes. This has been run on Mexican data and shows that up to 61 000 years of life could be gained every year in Mexico through a comprehensive strategy involving multiple prevention programmes. The potential health effects of individual programmes are illustrated in Figure 7.4. Combining several interventions to tackle unhealthy diet and physical inactivity is an efficient way of improving population health. The cost-effectiveness of a prevention strategy including a mass media campaign, food taxes and subsidies, nutritional labelling and marketing restrictions would be $ 3 460 per life year gained in good health (DALY saved). Such a comprehensive strategy can contribute to a package designed to tackle the main risk factors for chronic diseases, including also tobacco, alcohol, high blood pressure and high cholesterol. In Mexico, the package could be implemented for an annual cost of $ 4.5 per head based on standard resource requirements for the above interventions, valued at prevailing wage and resource price levels in Mexico (Cecchini *et al.*, 2010). Interventions to tackle unhealthy diets and physical inactivity would cost less than $ 0.8 per person. This low cost (comparable with those of other major emerging economies) provides a significant opportunity for acting promptly to tackle the problem.

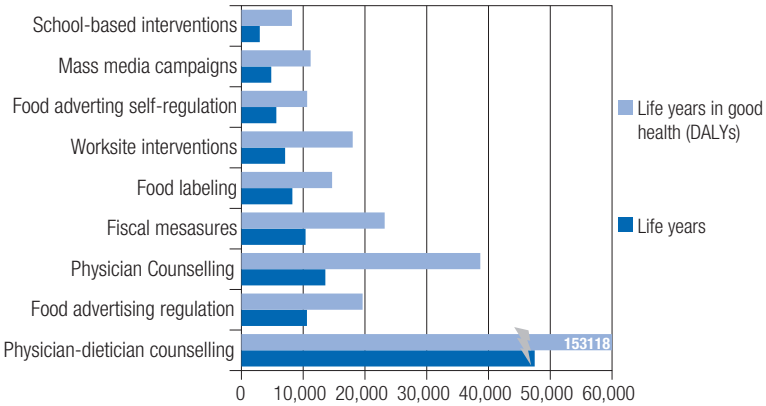
As in many other OECD countries, Mexico has given priority in the fight against obesity to initiatives aimed at school-age children, such as changes in school meals and vending machines, better facilities for physical activity, and health education. The 2012 Pact for Mexico gives also a special emphasis on children with a commitment to ban "junk-food" in schools (commitment 2). Overweight children have disproportionately high chances of remaining overweight as adults. Early dietary improvements may have significant effects on nutrition habits and tastes extending into adult life. However, policies targeting children may take a long time to produce a tangible impact at the population level, as reflected in Figure 7.4, and need to be coupled with interventions on adults who face a more immediate risk of chronic diseases. Many countries

Figure 7.3. **Obesity rates among adults, 2009 (or nearest year)**



Source: *OECD Health Data 2011*; national sources for non-OECD countries.

Figure 7.4. **Health outcomes at the population level (average effect per year)**



Source: Obesity and the Economics of Prevention: Fit not Fat. OECD, 2010.

also disseminate nutrition guidelines and health promotion messages such as encouraging "active transport" – cycling and walking – and active leisure. In the past three years, some, but not all, governments stepped-up their actions to improve diets and increase physical activity. Health promotion efforts were intensified, co-ordinated national programmes were launched in United States (*Let's Move*), United Kingdom (*Change4Life*), Switzerland (*Actionsanté*), and others. There has been an increasing reliance on partnership with the food and beverage industry (e.g. United Kingdom and Switzerland) in the design and implementation of actions to fight obesity, particularly in product reformulation to avoid unhealthy ingredients (e.g. saturated fats and too much salt), in reducing excessive portion sizes and providing healthy menu alternatives; in limiting advertising, particularly to vulnerable groups like children; and informing consumers about food contents. Efforts in middle-income countries tend to be less comprehensive, are often carried out as public-private partnerships and mainly focus on increasing physical activity. Examples of such actions include the Movimiento Benestar or the Agita Mundo action, both of which are carried out in many Latin American countries. Voluntary reduction of trans-fatty acids by the industry as well as regulation of commercial promotion of food to children are very limited but some countries (e.g. Chile, Colombia, Argentina and Brazil) initiated regulatory processes. The real novelty of the last three years has been a strong and increasing interest in the use of fiscal measures to limit the consumption of foods high in fat, sugar and salt. Legislation was passed by several OECD countries (e.g. Denmark, Hungary, France, Finland) and further countries are expected to follow through in the near future.

Mexico fares better on other major risk factors for health, such as tobacco and alcohol, whose consumption is lower than in most other OECD countries.

However, higher-risk individual patterns of alcohol use (e.g. binge drinking) appear to be relatively common in Mexico, which is a potential cause for concern.

Improving quality and efficiency of health care

While fiscal reform should help ensure adequate funding of the health system (see Chapter 2 on Fiscal policy) another important way of tackling emerging health needs, addressing funding gaps and providing for better financial protection, is by improving health spending efficiency and quality.

One of the greatest challenges is to improve the structure and organization of the system. Health service supply in Mexico remains patchy, with a large and mostly unregulated private sector and a public sector fragmented into several vertically-integrated bodies that both finance and provide health care, each covering different segments of the population different populations, with different regimes. As Mexico continues expanding the benefit package of the *Seguro Popular*, it will be important to seek administrative savings and better coordination of care by addressing the duplication of administration across 'silos' and by reducing high administrative cost. Currently, the co-existence of numerous vertically integrated insurers and the absence of separation between insurers and health care providers often means that health care facilities are duplicated in some areas. Mexico has taken steps towards integrating different health care bodies. For example, the Ministry of Health established an integrated health database and developed a common tariff system for all health-coverage bodies, while there is a degree of joint purchasing of patented medicines across different bodies (see below). Breaking down the current barriers between institutions, and creating a broad-based health system with a single insurance package that applies to everyone would greatly improve efficiency in health service delivery. In addition, the first commitment of the Pact for Mexico aims at making health coverage portable across institutions and address variation in quality and coverage across institutions. Addressing these major challenges will require reforming payment mechanisms to reward high performance; for example linking remuneration to performance goals and linking financing to services provided. Another important measure would be to strengthen common information systems, as well as reporting and accountability frameworks for all institutions. Further reform could relate to contracting arrangements between providers and financing institutions, in order to enable patients to access health care from the most appropriate service provider given their condition and location, rather than on the basis of their institutional affiliation. However, currently the quality and extent of care provided varies markedly across institutions. To bring the main institutions together will require more than giving power to patients; it will also require investment in the health workforce and a move towards a common package of health services, based on economic evaluation of their cost-effectiveness.

Lastly, to realise the commitment contained in the Pact for Mexico, it will be important to reduce differences in the quality of health care across the country by allocating limited resources where they are needed most. Public financing per capita continues to be inversely correlated with indicators of need, such as infant mortality, as well as with the neediest geographical areas. Poor-quality health care stems partly from an insufficient number of doctors and hospital beds. Despite a large increase in the supply since 1990, Mexico had just two doctors per 1000 people in 2010 compared to an OECD average of 3.1, only 2.5 nurses compared to an OECD average of 8.7, and the ratio of hospital beds was less than half the OECD average. There are also large regional disparities in the density of physicians and hospital beds per population, which is higher the main cities (OECD, 2011a).

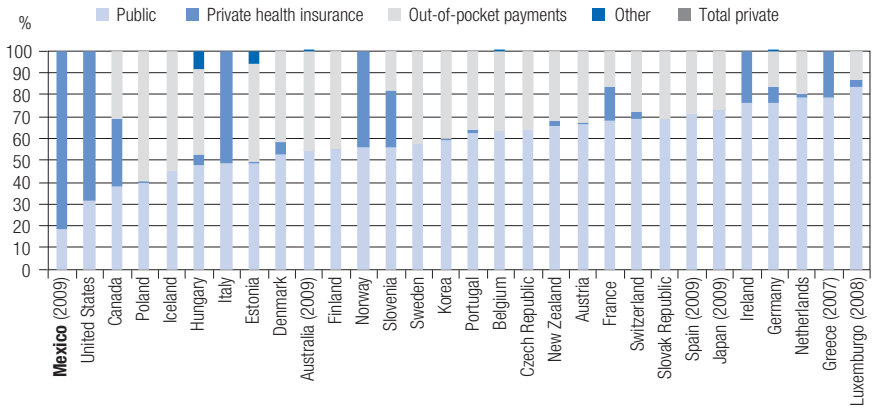
The example of pharmaceuticals

In most OECD countries, medicines are part of the benefit basket covered by basic health insurance, and Mexico has implemented policies to provide access to essential medicines – as defined by WHO – to the population. The Ministry of Health establishes reimbursements lists for primary care (*Cuadro Basico*) and for secondary and tertiary care (*Catalogo de medicamentos*), from which social security institutions and *Seguro Popular* draw their own "formularies". People insured through social security schemes or the *Seguro Popular* are entitled to free medicines, provided the medicine is included in the formulary of the affiliation institution, it is prescribed by a physician working in the public sector, and it is dispensed in a public pharmacy or outlet (Wirtz, 2011 and 2012).

Pharmaceutical expenditure accounts for 27.7% of total health spending and 1.7% of GDP, above OECD averages (16.7% and 1.5% respectively in 2010). However, 81% of pharmaceutical spending are financed privately, mainly out-of-pocket (see Figure 7.5). This results from a combination of high self-consumption (including self-consumption of prescription-only medicines which are too often dispensed without prescription) and low availability of medicines in public institutions.

The medicine market is also characterised by high prices and wide price variations, notably across states. To address inefficiencies in the market, the government imposed some regulations to improve procurement methods (see Knaul *et al*., 2012). Each institution has its own purchasing process for generic purchasing that takes place at the 32 States level (Moise and Docteur, 2007), a system that led to high, largely unjustifiable, price variations. A Commission created in 2008 has been negotiating nation-wide prices for patented medicine for all public institutions, leading to significant price reductions and savings (Gomez-Dantes *et al*., 2012). This is an important step since patented drugs still account for more than half of public purchasing in value -- though only 5.5% in volume (Wirtz, 2011). However, in the private market, price regulation only

Figure 7.5. **Pharmaceutical expenditures by financing agent in 2010 (or nearest available year)**



Source: *OECD Health Data* 2012.

consists of a maximum consumer price for patented medicines, resulting from voluntary agreements with manufacturers. This regulation leads to relatively high prices for Mexico because negotiating parties use as a reference the prices paid by countries with the highest volumes of sales (Moise and Docteur, 2007).

Since 2011, the OECD has supported two major public entities of the Mexican health sector, namely the Mexican Institute of Social Security (IMSS) and the State's Employees' Social Security and Social Services Institute (ISSSTE), in the improvement of their procurement activities (see Chapter 4). This includes a comprehensive review of their respective procurement function and provision of detailed recommendations to increase their effectiveness, efficiency and integrity (including on fighting corruption and bid rigging) (OECD 2011c , 2012b and forthcoming). Various initiatives were subsequently implemented, including joint competition in 2012 of almost 700 medical products (including non-patented medicines) and 600 medical equipments by numerous actors of the public health sector. The Mexican Institute for Competitiveness assesses that new projects initiated by IMSS in 2011 to address recommendations of the OECD have already resulted in important savings in procurement spending for selected medicines and in a 34% increase in bidders' participation (IMCO, 2012).

Lastly, while the availability of medicines in public institutions has improved (Knaul *et al.*, 2012), medicines still represent two-thirds of out-of-pocket payments for households covered by social security and 72% for households affiliated to Seguro popular.

Overall, further reforms are needed to improve efficiency in the purchasing and consumption of pharmaceuticals, and thereby also improve access to publicly reimbursed drugs for poor households.

OECD Key Recommendations

- Promote quality and cost-effectiveness of care by furthering illness prevention and health promotion initiatives, especially to address the growth in obesity and diabetes.
- Ensure adequate funding of the health system by introducing the necessary fiscal reforms.
- Reduce remaining barriers to access to services by improving service availability and quality and by progressively expanding the package of health care covered by the Seguro Popular.
- Over the longer term, create a broad-based health system with a single insurance package that applies to everyone and is portable across insurers.
- Further improve pharmaceutical purchasing and distribution processes, and the regulation of the private market. This will contribute towards further reducing price variations across states and purchasers, and increasing the availability of drugs at public providers.
- Increase efficiencies in purchasing practices and reduce the occurrence of bid-rigging practices through a more effective tender design limiting opportunities for collusive practices, and by training the procurement force at all levels of government on early detection techniques.
- Encourage greater efficiency of public providers of health services by introducing a clearer purchaser-provider split and output-based payment mechanisms.
- Improve governance of the system by strengthening information mechanisms and accountability frameworks for all institutions and by investing in managerial capacity at all levels of the system.

Further reading

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From:

Getting It Right

Strategic Agenda for Reforms in Mexico

Access the complete publication at:

https://doi.org/10.1787/9789264190320-en

Please cite this chapter as:

Colombo, Francesca*, et al.* (2013), "Health Policy", in OECD, *Getting It Right: Strategic Agenda for Reforms in Mexico*, OECD Publishing, Paris.

DOI: https://doi.org/10.1787/9789264190320-9-en

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