OECD MULTILINGUAL SUMMARIES

OECD Reviews of Health Systems
Mexico

Summary in English

The health status of the Mexican population has experienced marked progress over the past few decades and the authorities have attempted to improve the functioning of the health-care system. Nonetheless, health policy in Mexico faces important challenges in ensuring universal access to health insurance and enhancing the efficiency of the health system. The "Review of the Mexican Health System" first provides an overview of the system organisation, highlighting its main strengths and weaknesses. It then evaluates system performance against the policy goals of access, quality and responsiveness, efficiency and financial sustainability. Finally, the Review assesses recent reforms and their potential impact and areas where additional policies may need to be introduced to strengthen the system.

The Mexican health-care system is different from that of most other OECD countries

The public health-care sector is characterised by the presence of several vertically integrated insurer/providers, serving different parts of the population and with little connection between them. In addition, there is a very large, and mostly unregulated, private sector. Social security institutions cover salaried workers in the formal sector. Although estimates vary, individuals contributing to social security institutions and their dependents are estimated at around half of the population. The Ministry of Health, which provides health-care services to the population uninsured by social security, has decentralised most of the supply of care for those groups. The states now operate their own State Health Service systems of public hospitals and clinics. There are wide differences between states in the per-capita resources available for providing public health-care services and rural areas face particular problems of access. Each institution – whether state or social security – provides health services at all levels of care in their own facilities. The State Health Services (SHS) are perceived by the general public as providing lower-quality care than the social security system, although this partly reflects the fact that the resources per household allocated to the social insurers are roughly two thirds greater than those allocated to the State Health Services.

Doctors and nurses are salaried workers in all institutions which does not favour efficiency and a large proportion of doctors also have private practices, on a fee-for-service basis. The private-hospital sector provides around one third of all hospital beds in

the country. These are concentrated in larger cities in richer states with nearly half of private hospital facilities found in Mexico City.

Despite major improvements in health status and prevention, the system needs to improve performance

Mexico has seen dramatic improvements in life expectancy and a steady reduction in infant mortality rates since the 1950s. Mortality and morbidity patterns in most Mexican states are no longer dominated by communicable diseases and the share of chronic and lifestyle-related illnesses has increased. Nonetheless, Mexico remains below most OECD countries for a number of health status indicators. Child and infant mortality rates are the second highest in the OECD area after Turkey, while its maternal mortality rate is also much higher than the OECD average. Mexico is one of the few OECD countries that has not yet achieved universal or nearuniversal insurance coverage. The level of public spending, at 45% of total health expenditure in 2002, remains well below the OECD average of 72%. Most of private spending in Mexico is financed by out-of-pocket payments. The system is profoundly unequal in terms of access to health care, its financing, and health status indicators. Large disparities exist between the richer northern and the poorer southern states of the federation in insurance coverage, public expenditure and health status. While those not covered by the social security system can obtain care at government facilities, significant access barriers remain for those relying entirely on Ministry of Health and State Health Service facilities. Poorer households are less well covered by social insurance than richer households and a larger share of the poor also face catastrophic and poverty-creating health-care expenditures.

The level of public health-care spending – at 2.8% of GDP (2002) – is low by OECD standards. The supply of inputs into the health-care sector, such as practising doctors and acute care hospital beds, is also limited. Despite this, the intensity of use of these inputs is not high by OECD standards, signalling low demand and/or inefficient use of resources. The significant variability across institutions and across states in the intensity of use, suggests that there is scope for improving the performance of the weaker states and institutions. Administrative and governance costs also appear high by international standards, possibly reflecting the fragmentation of the health-care system. Plausible factors that might explain low efficiency levels include: the coexistence of numerous vertically-integrated insurers and the absence of any separation between purchasers and providers; difficulties in the coordination of policies in a decentralised environment; underdeveloped management capacity across decentralised institutions; and weak financial incentives associated with payment systems that do not reward productivity and quality.

While Mexican patients appear to be largely satisfied with the care they receive, the large share of private spending in total health-care expenditure raises concern about the quality of care and system efficiency and responsiveness. Lack of capacity to serve the health needs in the public sector has led to demand spilling over into the private sector where there is little insurance cover. Budgetary constraints have limited both the quantity and quality of care to the poor, leading to significant implicit rationing throughout the system. For example, availability of most drugs in the State Health Services is very limited. There are also reports of wide variability in quality across and within both the public and the private sector.

In addressing these challenges, policy makers are confronted with a number of policy constraints. The country is going through a demographic and epidemiological transition which is putting greater pressure on the health-care system. While Mexico spends less than other Latin American countries with similar levels of economic development, the absence of fiscal reform severely limits the scope for increasing government financing of the health-care system. Furthermore, the social security sector is facing budgetary pressures from increasing pensions for its workers. Finally the fragmentation of the institutional arrangements with the decentralisation of providers makes it more difficult to build a coherent strategy and create a consensus for change.

While an ambitious new reform offers new opportunities, challenges remain

Since the 1990s, the Mexican authorities have engaged in reform efforts to widen access to care for the uninsured population and improve the availability and quality of health services. The System of Social Protection in Health, the key reform of the present administration, aims to improving financial protection for those without social security coverage, inject new resources into the system, and re-balance the financial transfers from the federal government to the states.

The key element of the new reform is a voluntary health insurance option (the "Seguro Popular", or Popular Health Insurance) which will provide, progressively, coverage for a package of essential interventions and selected catastrophic treatments for households not covered by social insurance. The system is financed through new financial resources contributed by the federal and state governments for each newly affiliated family, topped up by a small income-tested premium paid by the family. Because funding is linked to the number of individuals enrolled, this new money will be primarily directed to those states with low levels of social insurance cover and which also tend to receive fewer resources from existing federal transfers. Conditional on budgetary resources being made available, inequalities between states in public-health care financing for the currently uninsured should be broadly eliminated by 2010.

With voluntary enrolment in the Seguro Popular, states have an incentive to affiliate as many families as possible and this should also encourage them to provide more and better quality services. Since health care services can be potentially supplied by any provider operating in the Mexican National Health System, it now becomes possible to move towards a breakdown of the current "silo" approach that underlies the existing organisation of provision. If the appropriate policies are put in place, this could encourage providers to improve quality and efficiency of provision as money would follow the patient. A separate fund is also established to finance public health and community health services, to ensure that public health services are not sacrificed during periods of budgetary restraint.

Despite the careful design of the new reform, successful implementation will remain a significant challenge to the Mexican authorities. First, the availability of fresh resources to finance the new programme remains conditional on the fiscal situation and, in this context, the OECD has emphasised the need for fiscal reform. Despite the recent reforms to the law governing social security, new pension arrangements are still under negotiation in the largest social security institution (IMSS) and pressures are likely to continue during

the transition period to a new system. The cost of pension arrangements for government workers also remains to be addressed.

Second, as the System of Social Protection in Health only covers a well-defined set of basic services and offers limited protection for catastrophic risks, pressures to expand such benefit coverage may arise from the users. Third, the new insurance system risks creating incentives for providers to give preference in treatment to the enrolee *vis-à-vis* those not enrolled in the new insurance scheme, especially during the transition period to 2010. Fourth, given new demand for public sector services, SHS providers will face the need to increase efficiency and quality, a key challenge, particularly in poorer states with weaker capacity and in rural areas. Currently, measures to encourage greater efficiency in the State Health Services have not been put in place and this policy area requires urgent attention to ensure that new resources under the System of Social Protection in Health are used to best advantage. Last, the success of the System of Social Protection in Health in the longer term will hinge upon its ability to break the link between financing and provision, thus avoiding continued fragmentation in the system.

Additional reforms are needed

This review presents several recommendations for tackling the weaknesses of the current system. Among the most prominent suggestions are the following:

- Introducing fiscal reform and implementing public-sector pension reforms to ensure adequate funding of the health system.
- Encouraging take-up of insurance under the Seguro Popular and tackling remaining barriers to access to services for those not covered by social security.
- Ensuring adequate financing for cost-effective "public health" goods such as prevention or epidemiological surveillance.
- Establishing a purchaser-supplier split with contractual arrangements between insurers and providers to reduce the current segmentation of the system.
- Re-investing un-necessary administrative costs in the supply of health-care services.
- Linking staff remuneration to performance goals and reviewing labour contracts to encourage greater professionals' productivity and eliminate practices that limit gains in efficiency.
- Furthering health-promotion initiatives and strengthening quality measurement and improvement initiatives to promote quality and cost-effectiveness of care.
- Strengthening information systems, reporting and accountability frameworks for all institutions, and investing in managerial capacity to improve governance of the system.