Addressing Inequity In Health And Health Care In Mexico

Mexico's health care system shares the problems of incrementalism with its neighbor to the north.

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PROLOGUE: Fragmentation and administrative complexity are often described as among the greatest weaknesses of the health system in the United States, especially in comparison with other countries such as Canada, our neighbor to the north. But in the following paper by a quartet of authorities on Mexico's nonsystem, it appears that our neighbor to the south has managed to outdo the United States in building a patchwork of "multiple, parallel" public and private arrangements.

The result is that half of Mexico's 100 million citizens are uninsured and more than half of the country's annual health spending is out of pocket. The authors find that incentives in this balkanized system tend to reinforce the entrenchment of its several disjointed sectors, impeding efforts to improve performance. Disparities in access and outcomes—a tenfold difference in infant mortality rates between the poorest parts of the country and the richest, for example—make the U.S. system seem equitable in contrast. The employment-based portion of the Mexican system is particularly problematic, since workers in some sectors of the economy enjoy a hybrid public-private system of coverage, while many others are uninsured and must depend on an uneven system of public clinics. The authors conclude that "comprehensive federal funding of a core package of services across all social groups must be the basis of universal health insurance."

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ABSTRACT: Despite the fact that life expectancy at birth in Mexico has improved from forty-two years in 1940 to seventy-three in 2000, major inequalities persist in health and access to health care. The Mexican health care system has evolved into a series of disjointed subsystems that are incapable of delivering universal health insurance. Without greatly restructuring the way health care is financed, performance with respect to equity will remain poor. This paper presents the inequities of the system and describes how the current system contributes to the status quo rather than redressing the situation. After tracing the origins of the present system, we discuss policy initiatives for moving toward universal health insurance.

The world health report 2000 proposes that national health care system performance be assessed not only by the average health attained by the population but also by how health status and the burden of paying for health care is distributed within the population.[1] This preeminent concern with equity is also reflected in the 2001–2006 Mexican National Health Program, recently released by the Ministry of Health.[2] For persons at the top of the socioeconomic spectrum, Mexico's multiple, parallel health care subsystems provide excellent care as assessed by any standard. But for those at the bottom of the distribution, the system provides little more than vaccination. In comparison with other countries in the Organization for Economic Cooperation and Development (OECD), except possibly the United States, Mexico still has an unacceptably large uninsured population that receives little preventive health care and faces substantial barriers when seeking curative care.

Throughout the world, inequity in health status has fallen faster than would be predicted based on changes in economic inequity.[3] This general improvement has many causes, including the diffusion of knowledge about safer health behavior (such as that related to water quality, sanitation, nutrition, and safer sex) and the diffusion of inexpensive, effective technologies (most importantly, vaccination and oral rehydration therapy, or ORT). Mexico has one of the world's most successful vaccination programs (coverage rates for many vaccines exceed 95 percent) and has successfully promoted ORT, dramatically reducing morbidity and mortality from childhood infectious diseases. Unfortunately, few opportunities remain to use these types of vertical, technology-based national programs to reduce large disease burdens.

Despite these achievements, gaps in health status are still wide and are especially evident when one compares population groups and geographical areas. For example, infant mortality rates range from nine deaths per thousand live births in the richest municipalities to 103 in the poorest. Indigenous communities have an infant mortality rate that is 58 percent higher and a life expectancy five years lower than the national average and ten years lower than in Mexico City or Monterrey, the largest urban centers. Forty percent of indigenous women have been shown to be anemic, compared with a national average of 26 percent. In the

indigenous communities of Guerrero state, the maternal mortality rate is 28.3 per 10,000 live births, compared with the national rate of 5.1 per 10,000 live births.[4]

These inequities in health status are mirrored in inequities in access to health services.[5] Mexico's state-level indicators demonstrate large disparities in access to publicly funded health services. A recent study by Rafael Lozano and colleagues comparing the pattern of disease in 713 clusters of Mexican municipalities confirmed these data; the study revealed even greater heterogeneity than expected. For example, the proportion of women who delivered infants in a hospital varied from less than 10 percent in the first (lowest income) decile to more than 80 percent in the tenth (the highest). Ranking the clusters from the study in increasing deciles by income (as measured by per capita gross national product, or GNP) revealed wide disparities in physicians and hospital beds per 100,000 population among income groups: Physicians per 100,000 rose steadily from fewer than five in the lowest income decile to nearly twenty in the highest; beds likewise rose from fewer than one per 100,000 to nearly fifteen.[6]

Unfair financing is the third and final equity-related concern of the Mexican health care system. In Mexico, 52.9 percent of total health spending is spent out of pocket (for expenses not covered by insurance). This percentage is 16.6 percent in the United States, 25.9 percent in Colombia, and 3.1 percent in the United Kingdom.[7] Even though almost all population groups have high out-of-pocket spending, according to the 1998 National Household Income-Expenditure Survey, 7 percent of families in the poorest decile incurred catastrophic health expenditures in the previous three months, compared with only 3 percent of those in the highest income decile. The study conservatively estimated that between two and three million (of a total of twenty-two million) households spend more than a third of their income on health care each year—an expenditure that can easily lead to or exacerbate poverty.

These data help to explain why equity—in health status, access to health services, and health care financing—has become the top challenge faced by the Mexican health system. In this paper we consider what characteristics of the system perpetuate such inequity and how structural reform could reduce it.

Mexico's Fragmented System

The current structure and financing mechanisms of the Mexican health care system are critical impediments to reducing health inequity and ensuring that all citizens are guaranteed access to a basic package of health care services along with protection from financial ruin as a consequence of ill health. The government maintains multiple, parallel health systems for different population groups, which end up creating incentives that maintain or increase inequity rather than channeling public resources to the most pressing needs. Although the U.S. system is much different than Mexico's, an analogous situation exists with the inequity in access to publicly financed health care (for example, poor children versus poor elderly

persons) observed as a result of the separation of Medicare and Medicaid.

■ **Structure of the current health system.** Mexico's 100 million inhabitants receive their health care from a health system composed of three principal subsystems: (1) a number of social security institutes that provide health insurance for the formally employed and their families (almost fifty million beneficiaries) and are financed by earmarked employer and employees payroll taxes plus legally mandated government contributions (the financing arrangements are further discussed below); (2) governmental services headed by the Ministry of Health and limited services from nongovernmental organizations (NGOs) for the uninsured population (estimated at around forty-eight million); and (3) a large private sector that is almost entirely financed out of pocket, as the private insurance market covers fewer than two million enrollees.[8]

■ **Social security sector.** The social security sector comprises a number of different institutions that provide a range of benefits (pensions, health care, disability and life insurance, and sometimes recreation and child care) for different sections of the formal labor market. By far the largest of these is the Mexican Social Security Institute (IMSS). Their organizational structure is similar to that of a large, vertically integrated, staff-model health maintenance organization (HMO).

The IMSS was created in 1943 in response to the political pressure of an emerging workers' class associated with the rapid industrialization process. The IMSS funding mechanism has its origin in mutual or benefit societies organized by workers at the turn of the twentieth century. Since its foundation, employers, employees, and the federal government have contributed to the scheme. Access to care was an important part of these needs, although it was conceived within broader welfare objectives: to provide workers with social security benefits, including coverage against various health risks; to provide financial security for retirement; and to protect against financial losses associated with disability or death.

Although affiliation has been mandatory for persons working in the formal economy, special voluntary insurance schemes have been incorporated over the years in recognition of the need to provide access to social insurance for a growing number of workers who are not subject to a formal employee-employer relationship. As formal employment increased, so would social security coverage eventually covering most of the population. However, political pressures from interest groups prevented the integration of population groups into a single social security institution; parallel social security institutions were set up for other formally employed workers, such as those in the federal government, the state-owned oil company (PEMEX), and the military.[9] As a consequence, over the years these institutions have each developed their own health care infrastructures, independently providing services to their affiliates by means of separate financing and delivery mechanisms.

■ **Ministry of Health.** The expansion of social security in Mexico, as in most

other employment-dependent insurance schemes, has been intrinsically tied to economic growth, industrial development, and urbanization. Unfortunately, the labor markets have not progressively formalized despite economic growth, and the financial crises of the late 1970s caused unemployment and nonformal economic activities to increase. For these population groups, in addition to those living in poor rural areas, access to social security has not been feasible. Consequently, the Ministry of Health became an increasingly important provider, covering the population that neither qualified for social security nor could purchase private insurance.

The Ministry of Health was created in the same year as was the IMSS (1943). In its early days its primary responsibilities related to public health, sanitation, and allocation of resources to the state public health services that delivered care for the uninsured population. Over time Ministry of Health health care has been increasingly delivered directly by decentralized state-level health services in facilities owned and operated by those services, although a large proportion of the primary care for the rural poor is delivered by an IMSS-administered, centrally run scheme called Solidaridad.[10] Both Ministry and Solidaridad health services are almost entirely financed by general tax revenues, with a small proportion (3.4 percent) financed by user fees.[11]

■ **Private sector.** Private medical care in Mexico is extraordinarily heterogeneous in quality and in the level of services provided. The great majority of private care is for-profit, although there is a small nonprofit/NGO sector. At almost all levels of socioeconomic status, people seem to prefer the "responsive" care they get in the private sector. Twenty-one percent of social security beneficiaries and 28 percent of the uninsured population reported having had their last ambulatory care delivered privately.[12] In the largest cities, excellent specialty-trained physicians and high-technology tertiary-care medical centers compete with similar U.S. centers to provide care for Mexico's wealthy. At the other end of the spectrum, large numbers of unregulated and unsupervised private physicians, often without residency training, work out of individual "clinics" to deliver health care mostly to the uninsured, who can afford to not use the underequipped and understaffed Ministry of Health facilities. Serving the same population, and often owned by the same physicians, are scores of private pharmacies that freely dispense prescription drugs (with the exception of narcotics and a small number of other controlled substances). Many physicians combine private (often solo) practice with public work at an IMSS or Ministry of Health facility.

■ **Health system statistics.** Health care accounts for 5.6 percent of Mexico's gross domestic product (GDP), and average per capita health spending is estimated at U.S.$240.[13] The social security sector accounts for 33 percent of total health spending. Ministry health services (including IMSS-Solidaridad) represent an additional 13 percent. The remaining 54 percent of health care spending is directly financed by households and serviced by the private sector, with 96 percent financed through out-of-pocket payments and 4 percent through prepaid insurance.[14]

The Ministry of Health has increasing responsibility for health system stewardship, including policy making, provider regulation, and information gathering. However, only 13 percent of the 4,000 hospitals in Mexico have thus far been certified, and there is still limited monitoring of physician quality.[15]

Since the creation of the main public institutions in 1943, no major changes in the structure of the health care system have been undertaken. As a consequence, the system has remained fractured between those with access to social security coverage and the uninsured.

Prospects For Achieving Universal Health Coverage In Mexico

The structure of the health sector in Mexico has impeded progress toward universal health insurance coverage in multiple ways. The current structure creates incentives for building strong separate institutions, even at the expense of the others. In thinking about reform incentives that drive the system, it is useful to consider the perspectives of the management or leadership of the various institutions, the trade unions in the health sector, and patient advocacy groups.

The existence of multiple parallel government-operated health systems is very different from the multiple private systems in other countries (such as HMOs, indemnity plans, and the like). A worker's health care provider is predetermined by type of employer. By limiting choice, the system removes any incentive for providers to contain costs and increase quality in order to compete for members. Even more importantly, the system gives no voice at all to "nonmembers" (since they cannot choose to join), thus limiting the possibilities to extend insurance coverage to less privileged social groups.

The problems of fragmentation are also paralleled among the management of the different public-sector institutions. Today there is relatively extensive collaboration and joint planning between the two main public providers (Ministry of Health and IMSS), but that is the result of individuals trying to resist the structural incentives to pull in competing directions, not the result of a stable alignment of interests and incentives.

The natural competition among institutions for resources has tended to concentrate resources where political and economic power is strongest—exacerbating rather than alleviating inequity. Total public spending on health accounts for about 3 percent of GDP, less than half of overall health spending, and much less than is the case in most other middle-income countries in Latin America.[16] Although we cannot demonstrate causality, it is certainly plausible that the fragmentation of public-sector institutions has interfered with the sector's collective ability to argue for increased resources. The system has probably also drawn public discourse toward the needs of the insured populations rather than toward the needs of the uninsured.

It is an unfortunate irony if, on the one hand, fragmentation reduces total available resources and, on the other hand, it creates duplication and inefficiency. The

result is that valuable resources that could be used to increase coverage and reduce inequity are wasted.

Should Health Care Financing Be Restructured?

Although protection against ill health has been deemed a constitutional right since 1983, more than half of all Mexicans remain uncovered by any explicit form of health insurance, and most pay for health care out of pocket. As a consequence, the Mexican National Health Program proposes as a goal for 2006 that every Mexican should have access to health insurance regardless of ability to pay, risk level, and employment situation.

An important attempt to change the financing structure of health care took place in 1997, when new legislation allowed for an equal federal contribution (general tax revenue subsidy) to finance health care for all households covered by the IMSS. Additionally, an opting-in scheme was devised whereby individuals could buy into the health component of social insurance. Despite its potential to increase insurance coverage, this initiative has not been fully exploited to attract people into the IMSS, because it is widely feared that adverse selection would make the scheme financially nonviable. Aside from this effort, federal appropriations for health care continue to be awarded erratically—mostly to deliver care for the uninsured—and based on a combination of political pressures and budgetary largesse.

Comprehensive federal funding of a core package of services across all social groups must be the basis of universal health insurance. Although no government is capable of providing comprehensive coverage for all health care needs, a list of federally funded, effective core services should be determined by available funds through explicit insurance coverage. Additional services can be financed by complementary sources including local taxation, earmarked payroll taxes, and private insurance. An increase in general taxation funding can reduce systematic disparities in health access, and equitable allocation rules would allow better risk diversification. Additionally, changing the financing structure to provide explicit service packages should promote effective entitlement of previously uninsured beneficiaries, similar to what is now observed for social security affiliates.

Implementation Concerns And Recommendations

If equity is to be the major objective of health system reform, then the policy and evaluation perspectives must be long term. Regardless of the speed of change in the financing and organization of the system, greater equity in health status can only be achieved slowly. Experience has shown that it will not be feasible to dramatically expand coverage using an employment-based social security model and that it is perhaps necessary to move toward a national health care system based primarily on a general taxation–funded scheme. Supplemental private insurance as well as social insurance funded through payroll and local taxes should be

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strengthened as a way to purchase more comprehensive insurance and improved hotel-like amenities. Different levels of supplemental insurance can accommodate the widely different demand for health care services in a society as unequal as Mexico's.

■ **Universal health insurance, the strategy.** Under a single universal health insurance scheme that explicitly covers a basic package of health care for all Mexicans, delivery of services could be organized in new ways that could include the private sector and ensure that existing public-sector capacity is better put to use on patients' behalf. It is not difficult to imagine arrangements by which patients could choose their providers, given enough information on what their benefits and rights were under the insurance scheme. This type of system could increase social capital insofar as patient choice is promoted through more information. It would also take the constitutional right of protection of health and turn it into an effective entitlement with explicit rights—something that today's beneficiaries of the federally funded Ministry of Health subsystem do not have.[17]

Unless a substantial federal subsidy is provided to all Mexicans, health insurance coverage will remain dependent upon increased employment and its formalization. With the observed increase in the informal economy, it would be inappropriate to depend once again on employment-related schemes. The creation of a single risk pool for the entire population, unrelated to employment, implies creation of a national health insurance, funded through general taxation and detached from current social security schemes.

■ **Financial reform.** This strategy requires that the system be structured by functions, rather than by population groups. In this way, it would be possible to implement a single central funding scheme and subsequently ensure that resources follow the patient, even across institutional barriers. Concerns for responsiveness and efficiency can be accommodated in an organizational design that develops new contractual and payment mechanisms between purchasers (insurers) and providers. This type of system would modify current incentives in order to improve both quality of care and efficiency within the system.

Moving away from a vertically integrated insurer–provider model to the separation of insurance and provision functions through the so-called purchaser-provider split can be done gradually with sufficient coordination within each institution. The introduction of greater choice of providers, cost-effective purchasing, devolved budgets, autonomous hospitals, and some degree of public-private provider mix are all important reforms that can be implemented within individual Ministry of Health or social security institutions but that require a gradual pace to allow for capacity building, evidence-based feedback, and policy reconsideration.

Financial reform nevertheless must be formalized through legislation. Without a structural financial reform, a more equitable basis upon which resources are raised, pooled, and directed to different population groups cannot be promoted. The potential for reform depends on whether there is enough fiscal margin to move from a payroll-based to a general tax–based health system. If substantial federal subsidies are to fund the reform, resource flows will be highly dependent on fiscal policies. In this regard, a major constraint to increased public expenditure is the current low level of fiscal income explained both by a small tax base and by high evasion rates. In 1998 Mexico's income tax revenue/total tax revenue represented only 4.7 percent/16 percent of its GDP, as compared with an OECD average of 13.5 percent/37 percent.[18] Consequently, a major fiscal reform that increased the tax base would be required to make the scheme sustainable in the long run.

■ **Political commitment.** Unfortunately, health care financing reform is difficult given the current situation of fiscal restraint and fragile new democratic institutions unwilling to upset powerful interest groups and trade unions with clear interests in maintaining the status quo. Political costs are clear regarding trade unions, since they are not expected to agree to lose independence and autonomy in the face of a unification of financing schemes. Current social security beneficiaries are another group that could see this change as a dilution of its current benefits. Strong efforts to reconcile these competing interests will be required, and the government will need to build a robust consensus among various groups, particularly among potential beneficiaries of the new scheme.

However, a clear statement from the current government was made, and both the Ministry of Health and the IMSS are moving to expand health insurance coverage. Although movement is in the same direction, the long-term convergence of these efforts into a single national fund requires explicit political commitment. This in turn requires deciding whether health insurance should be disentangled from social security or if the ministry's efforts at providing insurance should later merge with social security. Moreover, it implies that the IMSS and the other social security institutions should integrate in order to unify funds. Otherwise, fragmentation at the funding level will remain.

The political and economic costs associated with these decisions are high, but without a long-term planning horizon on these matters Mexico is unlikely to embark on a sufficiently ambitious reform process. Any short- or medium-term policies need to be consistent with the desired future for health care financing and its delivery. With pressures rapidly mounting, major changes in the system's structure will need to be planned and realized sooner than later. Whether these reforms are implemented gradually and incrementally or proceed at a faster pace will, as always, be the outcome of the changing mix of political will, the mobilization of civil society, and chance.

The authors gratefully acknowledge Lia Fernald for her assistance in reviewing and editing this manuscript. Although the authors are all federal civil servants or federally employed researchers, the comments and recommendations herein represent their personal views and not an official position of the Government of Mexico.

NOTES

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