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DEBATE-COMMENTARY

Editorial

Is Being Insured Sufficient to Ensure Effective Access to Health Care among Poor People in Mexico in the Long Term?

In May 2003, Mexico established the System of Social Protection in Health, under which a public health insurance program named "Seguro Popular" (SP) was implemented. This system sought to extend social protection in health to uninsured poor people and to gradually standardize benefits with existing health insurance programs targeting private sector and government employees. SP is a system of public health insurance coordinated by the federal government and operated by the state governments. It is a voluntary insurance program with subsidized contributions based on ability to pay, targeting the poorest uninsured households. Enrollment in SP is not dependent on current health status or preexisting illness, and there is no copayment linked to the health care received. It covers selected diseases that are associated with excessive health expenditures and offers medical services through a network of public health centers and regional and national hospitals to ensure access to outpatient, hospital, and specialized care, as well as medicines, laboratories, and other health services.

The initial Impact Evaluation Survey of SP in Mexico was performed in 2005 and 2006, after a very short period of exposure to the program (Frenk, Gomez-Dantes, and Knaul 2009). Researchers focused on identifying effects on health services utilization and access to health services as well as health outcomes. Gakidou et al. (2006) reported better financial protection among insured families compared to uninsured families. Other evaluations of the SP program, using cross-sectional information and applying semiexperimental approaches, were undertaken a few years later, applying statistical techniques such as instrumental variables and propensity score matching and taking advantage of the roll-out of the SP program at state and municipal levels.

These cross-sectional analyses reduce the bias resulting from self-selection of individuals to join the SP program. Significant effects of SP on better access and utilization of health services and medicines (Sosa-Rubí, Galárraga, and López-Ridaura 2009a; Wirtz et al. 2012), reduced health spending and catastrophic health expenditures (Gakidou et al. 2006; Knaul et al. 2006; Galárraga et al. 2010), and better financial protection among the poorest population groups (Garcia-Diaz and Sosa-Rubi 2011) were found in the short term. However, SP was found to have limited impact on health outcomes, mainly due to the short period of exposure to the program at the moment of these evaluations were performed. Only a few studies showed significant effects of the program on health outcomes such as the control of blood pressure (Bleich et al. 2007) and the control of diabetes (Sosa-Rubí, Galárraga, and Harris 2009b).

The analysis of the impact of the SP program on health care access and outcomes in the long term is more challenging, given the fact that the program has achieved high rates of coverage in its target population. This situation requires the application of new statistical approaches to analyze the impact of the program. In this context, the construction of a pseudo-panel (Meng et al. 2014) using cross-sectional information for several years, combined with other techniques such as instrumental variables or propensity score matching, seems very promising. Applying this approach, Rivera-Hernandez et al. (2016) suggested that older Mexican adults covered by SP have better pharmacologic treatment for diabetes than their noninsured counterparts. However, they found no impact of SP on either pharmacologic treatment for hypertension or nonpharmacologic treatment for either diabetes or hypertension. As the authors note, this study provides relatively little information about the effects of the program on health indicators, more than 10 years after implementation.

In terms of policy implications, Rivera-Hernandez et al. emphasize a current general concern about the actual access to health resources and the quality of services that SP beneficiaries receive when facing an illness. The question now is whether being an SP beneficiary is sufficient to ensure access to high-quality health services, effective medications, laboratory testing, and other interventions that are part of the specialized medical attention needed to treat the diseases covered by the program. Operating characteristics of the program, such as the lack of any copayment for services received and the low-income target population that cannot contribute to insurance premiums, make the program more vulnerable to financial insolvency. Efforts to keep the

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program solvent may limit the ability to provide effective coverage to beneficiaries.

Recent discussions in Mexico have focused on the need to improve preventive care among program beneficiaries, particularly for the most prevalent chronic diseases (e.g., hypertension, diabetes, chronic obstructive pulmonary disease) that pose a heavy financial burden to the health system. Given that many of these health conditions are related to unhealthy life styles (e.g., poor nutrition, lack of exercise, tobacco use), efforts to improve healthy behaviors in the SP target population could relieve financial strains on the program in the medium and long term. Policy makers will need to redirect efforts toward prevention and healthier lifestyles by implementing public health campaigns, and also by incorporating preventive health services as a key component of the SP program.

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