

## **B3 | REFORM OF THE MEXICAN HEALTHCARE SYSTEM: THE UNTOLD STORY**

Currently, there appears to be a wide consensus regarding the importance of Universal Health Coverage (UHC). However, there are at least two different understandings of this notion. The hegemonic one is promoted by, among others, the World Bank, the Rockefeller Foundation, the World Economic Forum, *The Lancet*, and partially the World Health Organization (WHO). Their notion is of a health insurance model with a basic explicit service package, usually quite restricted, and with a plurality of privately and publicly funded administrators and/or service buyers and providers, with payments based on income. The second notion is that of a single public tax-financed system based on the principle of equal access for the same health need. What is at stake is the choice between the logic of a competitive and commoditized health system and the logic of a health system driven by health needs.

However, both notions apparently defend the same values, such as the right to health, equity, universalism and solidarity, but the words have different meanings according to who uses them. We are, then, playing a role in a battle over discourse or participating in a sort of ‘ideological warfare’. The reason for this is that these are broadly held social values, and denying them openly is not a viable political strategy.

Countries in Latin America have been host to several ‘experiments’ in the arena of health reforms designed to promote UHC, beginning with the health and social security reforms in Chile in the mid-1970s, carried out by Pinochet. This trend has continued with a wave of neoliberal reforms in most countries in the continent during the 1990s<sup>1</sup> (ISAGS 2012). The most celebrated was the Colombian reform of 1993, which was recommended to other countries as a successful model. With the virtual collapse of the Colombian health system, a fact recognized even by the country’s government (Franco 2013), its place on the international scene has been taken by the Mexican health reform and its ‘Popular Health Insurance Programme’ (*Seguro Popular*). However, the supposed success story of *Seguro Popular* does not correspond to reality. This official account has been challenged (Laurell 2007), but the research has been ignored or has been labelled ‘grey literature’.

### **The Mexican health system**

In order to understand health system reform, it is essential to consider the structure of the health system that is being reformed, since this is what

modulates the process. The Mexican health system is segmented and fragmented, but it is predominantly public. The thrust for universal coverage for four decades rested on a social security strategy. By 1982, about 70 per cent of the population was covered by public social security, including a large part of the rural population. This public social security system had its own infrastructure and salaried personnel. At this time, private insurance and private healthcare provision were marginal (Laurell 2001).

The turning point came with the debt crisis in 1983 when structural adjustment was imposed by the International Monetary Fund (IMF) and the World Bank, and was consented to by the government. From then on, Mexican society as a whole has been reorganized on the premises and principles of neoclassical economics and neoliberal ideology. This has had a deep impact on the health system, but the public system is still strong and remains the main health service insurer and provider, while private commercial insurance and large for-profit hospitals play a minor role. Although private doctors and pharmacies play a role in the provision of ambulatory care, public providers attend to more than half of the population and play a dominant role in the provision of hospital care and in public health activities (Laurell 2013).

### **Reforms to promote a clear agenda**

The fiscal adjustment carried out for political and economic reasons subjected the health system to an abrupt decline in financing. The Ministry of Health suffered a huge direct budget cut, and social security revenues dropped drastically as a result of the decline in wages and formal employment. The underfinancing persisted for two decades and severely undermined public health institutions,<sup>2</sup> paving the way for neoliberal reforms in the health system.

The structural reform of the health system began in 1995 and is not yet concluded. It has gone through various phases, but the underlying conception is the same. The basic proposal is to introduce Enthoven's 'managed competition' (1988) in its Latin American adaptation – 'structured pluralism', as elaborated by Juan Luis Londoño<sup>3</sup> and Julio Frenk (1997) while acting as consultants to the World Bank. The scheme aims to separate the tasks of regulation, administration of funds/purchase of services, and provision of services. This splitting of functions is essential because it permits the introduction of markets and competition, and consequently allows for the commodification of the health system (see also Chapter B1).

The first stage of the reform (Laurell 2001) took place in 1995–97 and its main target was the social security institute for private sector workers, IMSS,<sup>4</sup> which alone held about 60 per cent of the public health funds. The reform changed the financing of health insurance, reducing the employer premium and increasing the government contribution about fivefold. Even so, the result was a drop in IMSS's total health fund. Additionally, the IMF's 'bridging loan' was made on the condition that private fund administrators would be introduced.

This part of the reform failed, essentially because of strong public resistance and the imminent threat that the social security for healthcare, available to a majority of the population, might collapse.

The second part of the reform consisted of the decentralization of the facilities of the Ministry of Health to the state<sup>5</sup> level and the provision of the ‘universal coverage’ of a small health package that included just seventeen interventions.

### **Health insurance: the fashionable ‘success story’**

The failure to establish a payer/provider split in the IMSS and the failure to introduce private health fund administrators led to a modification in the strategy when a conservative government won the presidential election in 2000. The new minister of health (Julio Frenk) set about achieving the conversion of the health system to fully fledged structured pluralism despite the severe problems faced by the twin reforms in Colombia after almost a decade of implementation. Accordingly, the National Health Law was modified in 2003 and the National System for Social Health Protection was established after some behind-the-scenes manoeuvring in parliament (Laurell 2007).

The *Seguro Popular* (SP) is the operative programme of the new system. It is a voluntary insurance scheme for people who are not covered by social security insurance and offers a basic explicit package of 274 interventions, including drugs and eight ‘catastrophic cost’ diseases for adults, while the medical coverage for children is broader. However, the SP excludes common high-cost diseases and conditions such as multiple trauma, cardiovascular disease, stroke, most cancers, and renal insufficiency. The SP package corresponds to 11 per cent of the package that social security provides for free. The SP is free for the lowest-income groups, and the rest pay a premium of about 3–4 per cent of their income (Laurell 2013).<sup>6</sup>

The SP is financed by federal tax funds, state tax funds and family premiums in amounts and proportions established by law. The organizational arrangements of the SP are administered by decentralized agencies at the federal and state levels (structured pluralism). The federal government collects, administers and transfers funds to state fund administrators based on the number of enrolled individuals, and also to a special fund for ‘catastrophic cost’ that buys personal health services for SP affiliates from public or private providers. Public health actions and collective health initiatives are financed by a special fund, and are the responsibility of the decentralized state health services.

The Ministry of Health claims that universal insurance coverage has been achieved in Mexico, thereby enhancing social security and strengthening SP. However, this claim is refuted by other official data sources such as the census and by health and income/expenditure surveys for 2012. These surveys demonstrate that 21–25 per cent of the population lack insurance coverage,

corresponding to between 25 and 30 million people. Nor is it true that the main SP beneficiaries constitute the poorest section of the population: 37 per cent of the lowest-income quintile of the population are uninsured. Official health statistics also show that the SP is providing far fewer services to its beneficiaries than the public social security system (see Table B3.1).

TABLE B3.1 Comparison of service provision by type of insurance

Type of service	Seguro Popular	IMSS
Consultations*	1.4	3.0
Emergency room care*	0.07	0.43
Hospital care**	2.7	4.8

Notes: \* per person; \*\* per 1,000 insured persons

Source: Laurell (2013)

The data show that insurance coverage does not mean access in the presence of a restricted service package. In the Mexican case, the unequal distribution of health facilities and human resources further restricts access, given that the expansion of SP enrolment was not accompanied by a commensurate increase in service facilities.

So far, the SP has contracted private providers only marginally, which means that the population, both with and without the SP, is attended to at the same facilities, but with one crucial difference: the SP population is accorded preference when it comes to receiving care, while the non-SP population is discriminated against in public facilities. A comparison of the access to care available to those having health problems between the uninsured, those with the SP and those with social security reveals that 15.9 per cent of the uninsured, 12.5 per cent of those with the SP and 6.4 per cent of those with social security failed to receive care. According to both the uninsured and the SP beneficiaries, the main causes for this failure were economic barriers. In this context, it should be noted that for each peso spent by those enrolled for the SP, the SP spent 0.93 pesos, while the same datum for those enrolled for social security is one peso to 1.39 pesos. The SP provides only slight protection against 'catastrophic health costs' for the insured as compared to the uninsured, but SP's affiliates still have to bear considerable out-of-pocket expenditure. It should also be emphasized that the overall proportions of public and private spending have changed very little.

Another shortcoming of the SP is that the amount of financial resources meant to be provided per person and supposed to be transferred by the federal government to providers is much lower than stipulated. The SP budget has increased by almost 300 per cent since it was started, but the health expenditure for the population without social security is a little less than the stated objective

of 1 per cent of gross domestic product (GDP). The Ministry of Health takes pride in the narrowing of the gap between per person expenditure for the SP and for social security, but does not note that per capita expenditure has been stationary with regard to social security beneficiaries.

### An uncertain future

The above provides a hint about the strategy for achieving complete structured pluralism. In 2015, the present government, it is understood, will announce the introduction of a ‘Universal Health System’. Under this, all Mexicans will be covered by a basic insurance that will grant access to an explicit service package and they will be able to choose their public or private provider freely. However, a closer reading of the hidden agenda behind this proposal shows that the service package is that belonging to the SP, the free choice of provider means that private providers will be promoted, and the social security institutes will be obliged to attend to everybody despite their overcrowded facilities. Since the basic insurance provides access only to basic services, a large space is created for the role of complementary private insurance. This means that about 50 per cent of Mexicans will lose most of their present health benefits or will have to contract such complementary private insurance.

However, the last part of the story, as described above, is hypothetical. As we have seen, health insurance available at present is far from universal; there is a lack of health facilities that can provide even basic healthcare; private providers driven by the profit motive are unlikely to fill the service gap; the payer/provider split has been unviable and has been resisted by social security institutes. Further, any move to deprive 50 per cent of the population of the benefits of health insurance is a major cause of political conflict. Finally, not unexpectedly, nobody has as yet proved any positive health-related impact of the reform of the Mexican healthcare system, and even its creators recognize that public health activities have been increasingly neglected by the government (Knaul et al. 2012). Commenting on this fact, the World Bank has argued that a health-related impact was not an objective of this reform! (Giedion et al. 2013).

### Notes

1 Latin America has also been a showcase for health-needs-driven, single and public health systems – for instance, in Brazil, Venezuela, Bolivia, Ecuador and other countries after the victories of progressive governments in South and Central America.

2 Social security institutes and the Ministry of Health.

3 The minister responsible for the reform of social security in Colombia.

4 Instituto Mexicano de Seguridad Social.

5 Mexico is a federation of thirty-two states.

6 The rest of the text is based on this reference if not indicated otherwise.

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