1. Introduction

Fairness in finance is an intrinsic goal of health systems. Achieving fair financing continues to challenge health systems in countries at all levels of economic development. Complex and differentiated healthcare institutions evolved during the 20th century alongside technological breakthroughs, yet effective, fair and sustainable methods to finance these systems are still lacking even in the most economically-advanced countries.

In most developing countries financial protection for health is partial and segmented. Mexico, a middle-income country characterized by social inequalities and a complex epidemiological transition, fits this description. The health system must still address the unfinished agenda of infectious diseases and reproductive health problems, while facing the increasing pressure on health expenditure associated with chronic disease and ageing.

In 2000, the WHO health system performance assessment ranked Mexico overall 51 out of 191 countries, yet 144 on financial fairness. The poor performance on fairness of finance reflects the fact that more than half of Mexican households lack health insurance and therefore financial protection. Lack of universal social protection in Mexico is intertwined with the existing health system segmentation between the formal sector, with access to social security, and the rest of the population that is excluded from this type of protection. This situation has contributed to the prevailing health inequalities and unfair health financing.

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Mexico recently devised a structural reform in order to extend social protection in health to families not covered by conventional employment-based social insurance.

The reform passed into law in April 2003, and the System for Social Protection in Health started operating on January 1st, 2004. The reform comprises an operational programme called Popular Health Insurance, which offers uninsured Mexicans voluntary access to publicly subsidized coverage for a comprehensive set of services at the primary and secondary levels, as well as a gradually expanding set of costly high-specialty interventions. It is expected that by 2010, at the end of a seven-year transition period, universal coverage will be reached.

Through the new System for Social Protection in Health, the reform will reduce economic barriers to timely care and prevent catastrophic expenditures while promoting efficiency, a more equitable resource distribution and better quality care. Thus, universal access to social protection in health should contribute to avoid impoverishment due to illness.

In this paper, I will focus on the ethical basis of the reform, its financial features, expected benefits, and future challenges. Finally, I would like to highlight some relevant aspects for other countries who are also striving to promote universal social protection as a means of achieving fairness, improving health and reducing risks that all too often generate poverty.

2. Poverty and health

Health has an intrinsic value (it produces well-being) and an instrumental value (it is an important determinant of economic development). The instrumental value is the result of the direct impact of health improvements on labor productivity and the economic burden of illnesses; but it also reflects an indirect impact on economic growth through education. Better health during childhood increases the opportunities to benefit from education and thereby to improve future income. Due to its direct and indirect impact, health is one of the important determinants of the incidence of poverty as well as its persistence over time, known as “poverty traps”.
Poverty traps that are created by an adverse health shock not only expose numerous people to poverty, but also exclude them from contributing productively to the economy. To avoid these consequences, it is important to have an adequate social protection framework that minimizes the impact of these shocks on families.

Health insurance is one mechanism that individuals can use to protect themselves from possible adverse health events. Individuals can protect themselves by acquiring private medical insurance or accessing state-sponsored insurance. Nevertheless, access to formal private insurance mechanisms is limited by insufficient information as well as by practices in which certain private providers of insurance get the most profitable part of the market. And access to state-sponsored insurance is often restricted to workers in the so-called formal sectors of the economy.

When people cannot insure themselves in the formal market, they can resort to informal mechanisms. Thus, when exposed to an adverse health shock, families can react by selling assets, using credit or finding additional sources of income, which can include child labor, and/or decreasing the consumption of other goods and services. All these methods, depending on their magnitude, can trap a family already in poverty or impoverish a family that was not previously poor.

These mechanisms that protect against health risks are actions that reflect the self-protection of individuals, households or communities. Despite the fact that informal markets and self-insurance are widely used by poor households, there is evidence that they are not enough to protect the household against the effects of adverse events on well-being. The lack of formal or informal insurance reduces an individual’s ability to smooth the intertemporal consumption of health-producing goods.

Low-income people who have no access to formal insurance mechanisms are exposed to a vicious cycle of illness and poverty. The money they must set aside to finance medical expenses frequently is a considerable burden, and the situation can become catastrophic. Based on existing literature, a family faces catastrophic expenses when it spends more than 30% of its total “payment capacity” to cover health costs. When this occurs, families
must adjust expenses for other goods, including perhaps money spent on the health and nutrition of young children. A catastrophic health shock could create a poverty trap for a large number of households. This situation does not affect all the population in the same way. Families are more likely to incur catastrophic health expenses or fall into a poverty trap as the income level decreases.

In order to comply simultaneously with the goals of equity and efficiency, the most appropriate option to protect the population is via health insurance. The advantages of insurance compared to other financing mechanisms lie in breaking away from accessing services by paying for care on an individual level, and establishing access according to the expected cost. Health insurance is also an instrument to subsidize health care financing between income groups or health risks.

In sum, social protection in health can contribute to alleviate poverty in two ways. First, through reductions in out-of-pocket expenses and thus in health-related impoverishment. Secondly, lower financial barriers increase access to services thus increasing their potential to improve health status.

3. Social protection as a strategy to promote fair financing: the recent Mexican reform

3.1 A fragmented system at the origin of the reform

The challenges faced by the Mexican reform of 2003 are rooted in the original design of the modern health system. In 1943, the Ministry of Health was established. The Mexican Social Security Institute (Instituto Mexicano del Seguro Social, IMSS) was created in the same year to attend to formal, private sector, salaried workers and their families. In 1959, the Institute of Social Services and Security for Civil Servants (Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado, ISSSTE) began to cover government employees and their families. The system was thus segmented -from its inception and through to the reform of 2003- between the insured, formal, salaried employees and their families with the right to social security, and the rest of the population (the self-employed,
the unemployed, non-salaried and informal-sector workers, and those who do not work). All citizens -other than salaried workers- were excluded from formal social insurance schemes and health care needs of this ‘residual’ group were attended by the Ministry of Health. The benefit package was undefined and funded from a combination of federal funds and, to a lesser degree, state-level contributions, as well as fees paid by families at point of service.

When the reform was passed in 2003, approximately 40% of the population was covered by IMSS, 7% by ISSSTE and no more than 2-3% by private health insurance. As a result, insurance coverage was regressive both between households and across states, there was an over-reliance on out-of-pocket spending to finance the health system, and impoverishing health spending was common particularly among the lowest income deciles. The reform addresses these issues by offering subsidized, publicly provided health insurance to the 50 million Mexicans who are not covered by social security and are concentrated among the poor.

The reform was passed into law in April 2003, and the new insurance scheme called the System for Social Protection in Health (SSPH) went into operation on January 1st, 2004 with the goal of achieving universal health insurance coverage by 2010. The Popular Health Insurance is the operational programme of the new system. The affiliation process runs from 2004 to 2010, so that 14.3% of the approximately 11 million families that make up the uninsured population will be included each year. Preference must be given to families from the lowest income deciles.

### 3.2 Ethical basis and key values behind the reform

There are five basic values behind the design of the reform: equal opportunity, social inclusion, financial justice, co-responsibility and personal autonomy. Based on these values, the reform seeks to change the Mexican health system from being segmented by population group, to being organized so that each institution fulfils only one of the three major health system functions of stewardship, financing and delivery, yet serves all of the social groups that make up the Mexican population.
Mexico is undergoing a profound political transition. Now that civil and political rights can be exercised by all citizens, it is necessary to complete the democratic transition by also guaranteeing the effective exercise of social rights, including the right to health protection. Although this right was formally recognized by the Mexican Constitution two decades ago, in practice, not all persons have been able to exercise it equally. Half of the population, by virtue of their occupational situation, enjoy the protection of social insurance and face fewer barriers to attaining health care than the other half who do not enjoy such protection.

For this reason, the guiding concept underlying the structural reform of 2003 is the “democratization of health”, meaning the effort to extend democracy to social as well as political and civil rights. The process of democratization is defined as the application of the norms and procedures of citizenship to those institutions that had been governed by other principles, such as coercive control, social tradition, judgement of specialists or administrative practices.

The new system is based on five key values that underlie the democratization concept:

a. **Social inclusion**, because all persons, regardless of socio-economic or labour market status, have the same right to health protection based on needs, so that the system is universal;

b. **equal opportunity** of all members of the society to the same quality of care and the same set of services defined by an explicit process of prioritization;

c. **financial justice**, whereby families contribute to the health system according to their financial capacity and at the same time receive health services according to their health needs, services are free at point of delivery, and a large financial pool of resources is generated that permits financial solidarity between the wealthy and the poor, the healthy and the sick, the young and the old;

d. **co-responsibility** between the different levels of government and among citizens;
e. personal autonomy based on subsidiarity so that decisions are made as close as possible to the source of needs and public institutions remain accountable to citizens.

### 3.3 Financial disequilibria in health care

The financial structure of the Mexican health system before the 2003 reform was marked by serious imbalances including: low overall budgets, high out-of-pocket spending, inequity in allocations between the insured and the uninsured, inequitable distribution among states, and excessive current versus investment expenditure.

First, in 2003 Mexico spent only 6.1% of GDP (approximately $360 USD per capita) on health care. This proportion was below the Latin American average and was too low to face the challenges of the epidemiological transition. Second, out-of-pocket spending accounted for more than 50% of total health spending and was above many Latin American countries including Brazil, Chile, Colombia and Costa Rica. Third, the distribution of public funds between population groups and states was also inefficient and inequitable. Although the uninsured accounted for almost 50% of the population, they received only a third of the federal funding for health. Fourth, the difference in expenditure per capita across states was 5 to 1 in 2003, and the difference in state contributions was much more dramatic. Finally, investment in new facilities and equipment had fallen leading to poor quality.

Regressive insurance coverage worsened the situation. While more than 60% of the wealthiest quintile of the population was insured, the figure was approximately 10% for the poorest quintile. Further, in the poorest states only one-fifth of households were insured. Each year, between two and four million households either spent 30% or more of disposable income (total income less spending on food) on health or crossed the poverty line due to health spending. Further, 85% of these households were uninsured and the majority was from the poorest deciles.

As a source of financing for a health system, out-of-pocket payments tend to be inequitable and inefficient. In Mexico, the predominance of this form of payment was both a cause and a result of the imbalances discussed above. Reducing it was thus a target of the reform.
3.4 **Social Protection in Health: objectives of the reform**

The structural reform of 2003 aims at assuring that all persons, independent of their labor market or socio-economic status, can exercise their social right to health care as recognized by the Mexican Constitution.

There are four main objectives to be achieved by the reform:

a. To generate a gradual, predictable, financially sustainable, and fiscally responsible mechanism to increase public expenditures in health so as to correct existing disequilibria;

b. to stimulate greater allocative efficiency by protecting expenditure for public health interventions that are cost-effective but tend to be underfunded;

c. to protect families from excessive health expenditures by offering a collective mechanism that manages in a fair way the risks associated with paying for personal health services;

d. to transform the incentives in the system by moving from supply-side to demand-side subsidies in order to promote quality, efficiency and responsiveness to users.

3.5 **Key features of the reform**

3.5.1 **Organization of financing according to the classification of health goods**

The allocation of federal funds in the new health system is divided into four main components: the stewardship role of the Ministry of Health; community health services; non-catastrophic, personal health services; and catastrophic, high-cost, personal health services.

The financial logic of the reform separates funding between personal and community health service by establishing a separate Fund for Community Health Services that is used exclusively to finance public health goods. This separation of funding is based on public goods theory and on the lessons learned from reform experiences that have neglected public health programs.
Funding for personal health services is based on an insurance logic to deal with uncertainty. The instrument devised by the reform to finance personal health services is a new scheme called Popular Health Insurance (PHI). For funding purposes, personal health services are divided between an essential package of primary and secondary interventions in ambulatory settings and general hospitals, and a package of high-cost tertiary-level care financed through the Fund for Protection Against Catastrophic Expenditures.

The essential package of interventions is a quality-assurance tool. These services are decentralized to the state level as they are associated with low risk, high probability health events. The package of catastrophic interventions is financed in a fund that aggregates risk at the national level because their low-probability and high cost imply that the state risk pool is too small to finance these interventions. Further, on the supply side, the requirements for highly-specialized interventions imply that it is efficient to aggregate services.

The essential package includes comprehensive ambulatory care at the primary level and outpatient consultation and hospitalization for the basic specialties at the secondary level. The Fund for Protection Against Catastrophic Expenditures covers a package of services that will be updated annually. This constitutes a priority-setting mechanism based on explicit, transparent criteria. The General Health Council is charged with defining the interventions covered by this fund, which currently includes: cancers, cardiovascular problems, cerebrovascular diseases, severe injury, long-term rehabilitation, HIV-AIDS, neonatal intensive care, organ transplants and dialysis. The criteria to select specific interventions are based on the burden of disease, cost-effectiveness, and resource availability.

3.5.2 Structure of financial contributions

The new Popular Health Insurance was designed so its financial structure would be similar to the tripartite logic of the other major social insurers (IMSS and ISSSTE). Thus, there are three public insurers for each of the three major population groups: PHI for previously uninsured families; IMSS for private sector workers and their families; ISSSTE for public-sector workers and their families.
There is a fixed contribution (the social quota) from the federal government that is equal for all families and guarantees solidarity among the three population groups. In January of 2004, the federal social quota was set at 15% of the mandatory minimum wage. This is equivalent to $230USD per year per affiliated family.

The second source of funding is from the co-responsible contributor and guarantees solidarity within each population group and redistribution between states. For IMSS, this is the private employer and for ISSSTE it is a public employer. In the case of the PHI, since there is no employer, co-responsibility is established between the federal and the state governments in a solidarity scheme that recognizes the huge differences in level of development among states. The federal solidarity contribution is on average 1.5 times the social quota, but is increased for poorer states at the expense of those that are wealthier. The state solidarity quota is the same in all of the states, set at half of the federal social quota and the source of funding is state-level revenue.

The third contribution is a premium paid by beneficiaries. In the case of the IMSS and ISSSTE, the employee contribution is set as a proportion of the wage and deducted from the payroll. The family contribution to the PHI is progressive and designed to promote fairness in finance. The upper limit on the family contribution is 5% of disposable income, which is defined as total spending less spending on basic needs. Families in the lowest two income deciles do not contribute in monetary terms, but are required to adhere to participation rules associated with health promotion. One contribution level is defined for each of the other income deciles.

3.5.3 Allocation of funding for personal health services

The allocation of funding from the reform is divided between federal and state levels. Based on actuarial calculations, the Fund for Protection Against Catastrophic Expenditures receives 8% of the federal social quota plus the federal and state solidarity contributions. The remainder of the social quota and the federal and state solidarity contributions are allocated to the states to fund the essential package of health services included in the PHI. The family contribution is collected and maintained at the state level.
The federal solidarity contribution is allocated to the states using a formula that considers a fixed component per family, a health needs-adjusted component, a component aimed at promoting additional state contributions, and a portion based on health system performance. The formula is designed to make up for historical imbalances and inequities, to respond to differential needs across population groups, to provide incentives for performance and affiliation, and to promote solidarity, universality and financial justice. For the first few years, the formula is heavily weighted on affiliation to accommodate the transition phase of the reform. The weights and indicators used in the formula are updated annually.

This funding model implies a radical change in incentives for state governments and providers. Funding for the states will be largely determined by affiliation to the PHI. Thus, the reform provides a legal framework to break out of discretionary allocations and move toward a demand-driven funding model that enables the effective use of an expanded health budget. In the past, federally-allocated state budgets in health were largely determined by historical inertia and the size of the health sector payroll.

Affiliation is voluntary, although states have the budgetary incentive to achieve universal coverage. Families who choose not to affiliate by 2010 will continue to receive health care through public providers, but will have to continue to pay fees for services received at point of delivery. The voluntary nature of the affiliation process is an essential feature of the reform that facilitates the process of replacing supply-side with demand-side subsidies so that money follows people. This process includes incentives for improving the quality and efficiency of health service delivery. In order to convince families to enroll the states must provide higher quality services than in the past. This process, combined with the focus during the first years on the poorest families, will help to prevent problems of market failure such as adverse selection.

Although the financial trigger is a demand-side subsidy, the additional funding mobilized by the reform is channeled to strengthen the supply side in line with the expansion in affiliation. This is changing the inertial aspects of historical budgets that were mostly used to pay for personnel costs. In contrast, the new funds cover drugs, equipment, extended hours at clinics, and enhancing or building facilities. Providers may be public or private.
3.5.4 Implementation phase of the reform: results and challenges

Implementing the reform presents a series of challenges, yet progress after the first year is positive. In order to achieve the goal of affiliating all uninsured families by 2010, roughly 1.5 million families (about 6 million people) must be enrolled each year. This process is moving ahead. The affiliation goal was achieved in 2004 and is on track in 2005 with an average of 45,000 new families affiliated each week. Affiliation must continue to proceed as rapidly as in 2004 in order to achieve universal coverage by 2010.

Another positive result is that the new system is fully operational and gradually expanding coverage in all of the 32 Mexican states. While most states are still at partial coverage, it is expected that five will reach universal coverage in 2005 and another seven in 2006.

It is important to note that, as stipulated by law, the enrollment process has focused on the poorest families who do not contribute financially. Based on data from the affiliation rosters of the Ministry of Health, over 90% beneficiaries are from the poorest quintile of the income distribution. Further, an important result in promoting equity is that more than 70% of the affiliated families are female-headed. This reflects the overrepresentation of singly mothers among non-salaried workers.

A behavioral indicator of satisfaction is the willingness of families to renew their yearly enrollment. The data are encouraging as 98% of families that participated in the 2003 pilot phase decided to re-affiliate in 2004. A challenge for the future is to maintain this rate of re-affiliation as the reform proceeds to cover larger numbers of families and those that will be contributing financially.

Additional public funding is required for the reform to achieve universal coverage. Initial estimates suggest that total public spending should increase by about 1% of Gross Domestic Product (GDP) to complete the reform in 2010. Again, initial results are encouraging as the reform has generated an increase in funding for the uninsured through the Ministry of Health and the states. In order to be able to accommodate the new entitlements, the authorized budget of the Ministry of Health for 2005 increased by 55% in
real terms over the 2002, pre-reform level, and 37% as compared to 2004. This has generated a gradual yet continuous trend of improvement in the distribution of public funding between the insured and the uninsured. In 2001, 33.3% of all public funds for health were allocated to the uninsured population and the rest to families with some form of social security. In 2004, the proportion spent on the uninsured and families affiliated to the Popular Health Insurance scheme reached 35%. The balance should further improve in 2005.

The budgetary increase comes from improvements in taxation and reductions in other areas of the federal government. Additional resources to accelerate access to priority, high-cost interventions, such as childhood cancer, come from an earmarked contribution on cigarette sales that supplements the Fund for Protection Against Catastrophic Expenditures.

If universal coverage is to be achieved, this process of increasing investment in the health sector, and in particular in the population not covered by social security, must continue. The funding commitment is a particularly important issue in the face of the change of government that will take place at the end of 2006. Maintaining the pace of enrollment and improving the quality of care are key to garnering the policymaker and patient support that will be necessary to cement the reform in the face of the political transition.

Another set of challenges are related to converting the system to being more client-oriented and responsive. The population must have greater confidence in public services to be convinced to make a financial contribution and to re-affiliate. This is particularly important in the face of the rising expectations that have been generated by the reform. On-going monitoring of patient satisfaction, affiliation, and re-affiliation, as well as in-depth, regular surveys are being undertaken.

An important ingredient for the reform is strengthening provider incentives and developing a more competitive environment on the supply-side. Shifting the focus of incentives to the demand side, while also strengthening and making more competitive the supply side, constitutes a delicate balance. This is related to the portability of insurance coverage which in turn depends on establishing compensation mechanisms among states and providers,
and on improving the availability and quality of services, particularly in more remote regions.

To meet these challenges in the face of rapid organizational and systemic change, specific measures to strengthen the health care system include increasing the number of hospitals and clinics, building up human resources particularly at the management level, and improving drug procurement. This work is part of a national programme launched in 2001 to improve technical quality and interpersonal responsiveness throughout the system. The program includes accreditation of providers and, by law, only certified providers will be able to participate in the new system. It also seeks to empower consumers to demand accountability through a bill of rights for users and a procedure for incorporating complaints and suggestions.

Evidence and information are important tools for successfully meeting the challenges of implementation. Rigorous analysis has been part of the reform since the design phase and a comprehensive regime of monitoring and evaluation accompanies the implementation process. One example of this is the comparative analysis of performance indicators across states that has been published in annual reports since 2001. Publishing these data promotes institutional improvement as they are used for the budgeting formula for states and as public reference points on system performance.

A final challenge is to involve in the reform process the diversity of actors in the Mexican health system including the Congress, IMSS, ISSSTE, the states, other government agencies and the private sector. Particularly important for the change of administration in 2006, the reform must maintain a broad support base among policy makers as well as the population to assure continuity.

4. Conclusions and relevance to other countries

The reform of the Mexican health care system is designed to gradually correct major financial disequilibria. The source of health finance is shifted toward publicly organized insurance. The distribution of finance among population groups and among the states is balanced.
To accomplish this, funding for public health services is protected and separated from funding for personal health services. Services at the tertiary level are covered by a national fund to aggregate risks. The package of covered services is based on explicit criteria of cost-effectiveness and social acceptability. The allocation of funds to the states is based on a redistributive formula to transform budgeting from an inertial, bureaucratic supply-side logic to a performance-based, demand-side subsidy.

The reform presents a series of challenges that are being met as part of its implementation and others that are evolving with the extension of coverage and changes in the policy climate. Meeting these challenges is producing knowledge on the management of the health reform process.

The Mexican reform experience is relevant to other countries in at least three senses. First, the reliance on out-of-pocket spending, inequality in the distribution of health contributions, and catastrophic and impoverishing spending on health are issues that face many societies, particularly middle-income countries. The reorganization of financing in the Mexican health reform seeks to respond to these issues, and this experience may be of value to other countries. The Mexican reform builds on earlier and ongoing experiences in other Latin American countries such as Chile and Colombia, where the expansion of insurance coverage was a driving force. Second, the Mexican reform was designed and is being implemented subject to budgetary restrictions so that incentives, efficiency, consumer satisfaction and accountability aspects are especially important. Again, these lessons are of relevance since improving health systems typically occurs in a context of resource scarcity. Finally, the reform has stressed the role of health in the process of economic transition and thus provides lessons on how to position the health sector in the context of economic development and in the minds of economic policy makers.

The Mexican case is relevant to other countries as it also illustrates the importance of simultaneously building the three pillars of any reform effort: ethical, technical and political. With regards to the first pillar, the Mexican reform was formulated on the basis of ethical deliberation that made explicit the values and principles underlying the proposal.
The technical pillar was built on the basis of extensive evidence derived from national studies and also from the adaptation of knowledge-based global public goods, such as conceptual frameworks (e.g., the WHO Framework on Health System Performance), standardized methods (e.g., the household income and expenditure surveys) and analytical tools (e.g., national health accounts). In this way, the Mexican case goes beyond the false dilemma between knowledge and action, showing how formal analysis serves to place a hitherto neglected problem at the center of the policy arena. It also demonstrates the falseness of another common dilemma, between global and local realities, as it adapted global public goods to national decision making that may further build the global pool of knowledge about health system reform. The process of developing the reform benefited from, and seeks to contribute to, the evidence on health sector reform, health system finance, the analysis of the fairness of finance, and health system performance assessment.

Finally, the political pillar was developed through a strategy that included bringing the ethical and technical elements to bear on the consensus-building process that eventually yielded a solid legislative majority in favor of the health reform. Perfecting evidence as a global public good implies promoting its use for national policy formulation, as well as intensifying the use of national analysis in developing international evidence.

The Mexican reform contributes to this process. International evidence, frameworks and methodologies were extensively used for advocacy, design and implementation. National evidence, such as the information put forward in this paper, should be important for stimulating a process of shared learning among countries that face the common challenge of improving health through equity, quality and financial protection.
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