ACHIEVING UNIVERSAL HEALTH COVERAGE IN MEXICO

THE CASE OF "SEGURO POPULAR"

Master of Arts in Law and Diplomacy Thesis

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May 11th, 2010

http://fletcher.tufts.edu

THE FLETCHER SCHOOL

TUFTS UNIVERSITY

“Achieving universal health coverage in Mexico: The case of Seguro Popular"

“Health is a fundamental right of every human”

Constitution of the World Health Organization

Salomón Chertorivsky, head of the Mexican government program Seguro Popular, was sitting in his office in January of 2010. President Calderón had asked Chertorivsky and Minister of Health José Ángel Córdova to brief him the following week about progress towards achieving universal health coverage by the end of his Administration. The creation of Seguro Popular in 2003 had represented an extraordinary achievement for health policy in Mexico: it had made access to health care a reality for millions of low income Mexican families. Despite the groundbreaking reforms enacted during the previous government, several issues remained unresolved by the time Calderón took office in December of 2006. The successful adjustments made to the program as it was aggressively expanded during the previous three years had made the goal of universal access to health seem possible. However, Chertorivsky knew there was still a long way to go and as he prepared to brief the President he reflected on the many hurdles that the government would need to surmount in order to achieve it.

1. Background

With a GDP per capita of US$13,200 in 2009(81 CIA 2009), Mexico is considered a middle-income country. While real income per capita has grown over the last decades, the distribution among the population remains very unequal. The economic model followed by the country has been unable to reduce the economic and social inequalities between the poor and the rich population. The Federal Government has implemented several policies to reduce inequality, but Mexico still registers a Gini coefficient of 48.2(81 CIA 2009), one of the highest in the world. Mexico's social inequality is not only reflected by income distribution, it can also be seen in differentiated access to basic services such as education and health. Historically governments have claimed to use social policy to tackle inequality in Mexico but the traditional social protection programs are highly regressive (See Exhibit 1).

The traditional public health system was created in the early 1940's and is funded through a combination of general revenues and payroll taxes paid by both employees and employers (37 Frenk, J. 2006). Entities funded under this tripartite scheme provide both health care and health insurance and workers are assigned to a provider depending on the sector in which they are employed.[1] This design separates the population into formal salaried workers with access to public health insurance and informal uninsured workers. The latter include the self-employed, unemployed, non-salaried and those outside of the

[1] IMSS covers private sector workers, ISSSTE government workers. The public oil company PEMEX and the Armed Forces operate their own providers. There are also numerous private health insurance and health care providers and the Ministry of Health nominally provides health care for uninsured population.

workforce (80 Knaul, Felicia Marie 2006) . In other words, the traditional health system provides insurance to only a fraction of the population. Hospitals directly operated by the Ministry of Health were created to provide health care for the uninsured (also called open population), but they are grossly insufficient to cover the informal sector, which represents 28.32 percent of the total workforce (61 INEGI 2010) (See Exhibit 2).

a. Health Financing

The Ministry of Health was founded in 1943. That same year, the Mexican Social Security Institute (IMSS [2]) was established with the purpose of providing health services and pensions to the emerging working class composed of salaried workers in the formal private sector[3]. In 1960 the federal government created the Institute of Social Security for Civil Servants (ISSSTE[4]). Later on, PEMEX[5] and the armed forces created their own providers of both health care and health insurance.

IMSS receives its funds from three different sources: employers, employees and the federal government (also known as the social quota[6]). Similarly, ISSSTE receives funds from workers and the federal government, which contributes as an employer and with the social quota. PEMEX and the armed forces are funded by a similar scheme. As previously

[2] IMSS – Instituto Mexicano del Seguro Social

[3] All the principal provider of medical services also covers the families of the workers

[4] ISSSTE – Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado

[5] PEMEX – Petróleos Mexicanos

[6] Social quota is a fixed contribution from the federal government that is equal for all families.

mentioned, the Ministry of Health (MoH[7]) also provides health services directly and the funds to finance them come from general revenues, state contributions and user fees.

Without a salaried job in the formal sector, affiliation to any of the four major providers was not possible in Mexico before 2003. In 2000 IMSS covered 40 percent of the population[8], ISSSTE 7 percent and private health insurers 2 to 4 percent. The remaining 50 percent of the population – some fifty million people- was uninsured (37 Frenk, J. 2006).

During the 1943-2003 period, the uninsured received health services through the MoH. However, the services provided were of poor quality, infrastructure was old and insufficient and treatment was restricted to a short list of diseases. The uninsured had to share the burden of treatment costs through a co-payment in order to receive medical attention from MoH. The contribution was adjusted by household income and subsidized by the federal and state governments, but out-of-pocket costs were still high relative to payment capacity[9].

b. Health and Inequality

As mentioned before, the structure of public health insurance in Mexico is regressive because most of the spending ends up benefiting a relatively wealthy segment of the population. The design of the traditional system reinforces inequality because the poor

[7] MoH – Secretaría de Salud

[8] Total Population of Mexico in 2000, 98, 438.6 millions (INEGI, 2010)

[9] As noted before, only the workers in the formal sector have access to free health services, the workers in the informal sector have to pay for health services. Usually, poor people use medical services from the Ministry of Health that requires an upfront co-payment to receive the services.

are left unprotected against catastrophic health expenditures and they lack access to preventive health services (Knaul, et al. 2006). Inequality of health coverage in Mexico is not only a result of the regressive funding mechanism of the health system. It is also due to unequal distribution of resources among the 32 states in Mexico.

c. Investment in Health

In 2000 Mexico's total expenditure on health represented 5.6 percent of GDP[10] (OECD, 2010), a low rate when compared to the Latin American average of 7 percent in the same year (84 Nigenda, Gustavo 2005). In particular the rate of spending on health seems particularly low when Mexico is compared with countries that have similar levels of income such as Costa Rica, Brazil and Uruguay, which were spending 9.3, 7.9 and 10 percent respectively in the same year (58 González-Pier, Eduardo 2006) (See Exhibit 3).

Not surprisingly, Mexico ranks low on health public spending when compared to OECD countries. Exhibit 4 shows that total private spending accounts for more than half of the total spending on health in Mexico (OECD, 2009). By 2003 Mexico had increased public health expenditure to 6.1 percent of GDP[11], but it remained below the Latin American average.

As a result of the low levels public spending, out-of-pocket expenditures represented more than 50 percent of health spending in 2006 (See Exhibit 4). Additionally,

[10] Total GDP Mexico 2000 - 985.89 billion US dollars, current prices and PPPs (OECD, 2010)

[11] Total GDP in Mexico 2004 - 1 185.78 billion US dollars, current prices and PPPs (OECD, 2010)

when compared to the average out-of-pocket spending in Latin America, Mexico presented higher levels than Brazil, Chile, Colombia and Costa Rica (80 Knaul, Felicia Marie 2006).

The low rate of government spending in health was only one of the financial challenges that the system faced. The distribution of funds among states was inefficient and inequitable. Decisions on how to allocate funds tended to intensify health access inequality. Access and spending on health were reported to be lower in the poorest states of Mexico and higher in the richer states. Chiapas and Oaxaca, two of the poorest states registered the lowest rates of insured population in 2000 (80 Knaul, Felicia Marie 2006).

d. Catastrophic Expenditures

Since the poor were generally uninsured, they were the ones using the services provided by MoH more frequently. Health spending was a heavy burden to poor families as co-payments often represented a catastrophic expenditure (37 Frenk, J. 2006). The World Health Organization (WHO) defines spending on health as "catastrophic" when a household allocates more than 40 percent of the available income to pay for health services (85 World Health Organization 2007). This type of spending is considered catastrophic because it puts the household at high risk of being impoverished or of worsening their impoverishment if they are already poor.

The WHO considers out-of-pocket spending the most inefficient and inequitable way to finance a health system (80 Knaul, Felicia Marie 2006). It also identifies several harmful effects of high out-of-pocket expenditures on health. On one hand, people that have to use family funds to access health services frequently decide to stop receiving any medical

attention or postpone treatment, resulting in higher medical risks and increases in future health costs. On the other, those who pay for medical attention out-of-pocket have to cut other basic expenditures like food, clothing, schooling or housing.

In 2000, WHO estimated that Mexico was amongst the countries where families spent 50 percent or more of their non-food budget on health, making them more prone to impoverishment as a consequence of out-of-pocket health spending (85 World Health Organization 2007). In that year, between 3 and 4 million Mexican families (3.4 percent) reported catastrophic expenditures in health services and 3.8 percent suffered impoverishment because of them (80 Knaul, Felicia Marie 2006).

In Mexico, out-of pocket expenditure has been shown to be more frequent for the poor than for the non-poor. Lack of access to health insurance partly explains high rates of out-of-pocket spending among the poor. Only 10 percent of the poorest quintile is insured, compared to more than 50 percent for the richest quintile (84 Nigenda, Gustavo 2005).

e. World Health Report 2000

Changes in the needs of citizens have broadened the goals of health systems around the world. Today, in addition to providing good quality health services, they are responsible for providing financial protection against catastrophic costs of financing illness (39 World Health Organization 2000) . The World Health Report 2000 not only examined access and coverage of health services around the world, but also goodness and fairness of the systems. The WHO defines g*oodness* as the ability of the system to respond to what people expect

from it and *fairness* as the equality of the system among the population (39 World Health Organization 2000).

The report played an important role by bringing attention to the inefficiency and inequality of the health system in Mexico, as well as its failure to provide financial protection to the poor. The Mexican health system ranked 144 among 191 countries in terms of fairness[12] Mexico was ranked close to countries that have much lower incomes and are less developed: Mexico was placed below countries like Benin, Uganda and Yemen (See Exhibit 6).

The report also brought attention to the high rates of catastrophic health spending and the corresponding impact on poverty levels. The timing of its publication was crucial, as 2000 was also the year Vicente Fox from the National Action Party (PAN[13]) won the presidential election after more than seventy years single party rule by the Institutional Revolutionary Party (PRI[14]). The findings of the report combined with the historical change of the political system in Mexico provided the right environment for health reform to be undertaken.

[12] Somalia was ranked 191 on fairness of financial contribution to health services by the WHO Report.

[13] PAN - Partido Acción Nacional

[14] PRI - Partido Revolucionario Institucional

2. Health Reforms 2000-2006

Taking the World Health Report 2000 as a platform, the Fox administration embarked in a long and complex process to reform the health system. The priority for the new administration was to address the effects of inequality and catastrophic expenses, especially among the poorest and most vulnerable sectors. The new minister of health, Dr. Julio Frenk identified three main challenges that needed immediate attention if Mexico was to have a modern and inclusive health system: equity, quality and financial protection (59 Secretaría de Salud 2001).

In order to meet these three challenges, the Mexican Government presented the National Health Program 2001-2006[15]. This document presented for the first time the aspiration of universal health coverage which entailed providing health insurance and financial protection to 50 million uninsured Mexicans. The Program set five objectives for the six year period: 1. Improve the health conditions of all Mexicans; 2. Address health inequalities; 3. Improve the responsiveness of public and private services; 4. Ensure fair financing for health and, 5. Strengthen the institutional framework of the health system (59 Secretaría de Salud 2001; 40 Frenk, J. 2003).

Frenk knew that to be able to meet these challenges, a structural reform to the Mexican health system was in order. The first step was to reform the General Health Law.

[15] The National Health Program 2001-2006, was on line with the remarks about the Mexican health system on performance, equity, quality and financial protection.

In November of 2002, Fox sent a health reform bill to Congress. The process to reform the General Health Law was one of the most difficult challenges faced by the Fox Administration, but it opened the way for the creation of Seguro Popular. The design of Seguro Popular took two years and required the involvement of Congress, state governments, unions and health experts.

Frenk recalls the health reform negotiation as one of the most challenging moments of his career. Mustering a majority in Congress was only one of multiple hurdles. He also had to overcome other obstacles such as widespread misinformation, skepticism, financial constraints, political interests and resistance by IMSS. In order to do this, he developed a conceptual framework based on three pillars: technical, ethical and political.

a. Health and Economics

The technical pillar was key to changing the misperception among the general public that the health system was mostly financed by public spending, when the reality was that in reality most resources came from private spending. Frenk relied on a study called "Health and Economics" by Fundación Mexicana para la Salud[16] (62 Frenk, Julio 2009) that quantified for the first time the financial structure of the Mexican health system and the magnitude of private spending on health(62 Frenk, Julio 2009).

The study showed that most of the spending on health came from the private sector, in particular from out-of-pocket payments. It presented evidence that that private

[16] Fundación Mexicana Para la Salud (FUNSALUD) is a private think tank that conducts research about health policies in Mexico.

expenditure represented 52 percent of the total expenditures in health in Mexico (Frenk, Seguro Popular 2010). The concepts of catastrophic expenditure and the impoverishment effects for families were also introduced for the first time to the public by this study.

Frenk also appealed to the ethical pillar to support the proposal of Seguro Popular and universal health coverage. The results of the study showed that Mexico was spending three times more public resources on the insured than on the uninsured population. In some ways the coverage system was valuing more the health of formal than of informal workers (62 Frenk, Julio 2009). The ethical implications of this were serious and access to health coverage was thus brought to the realm of human rights while it took a central place in the health reform debate.

Wielding the empirical evidence, Frenk was able to address the tough questions posed by members of Congress, economists and the press. The clever combination of technical and ethical arguments allowed Frenk to galvanize public opinion in support of the reform and managed to place public health atop of the political agenda.

b. Piloting Seguro Popular

The MoH encountered high levels of skepticism about the potential effectiveness of Seguro Popular among key stakeholders of the reform. The uncertainties were focused on the ability of the program to target the poorest workers who were frequently employed in the informal sector of the economy. The skepticism was high among policymakers, since there was no previous experience with a similar scheme.

To address this challenge, Frenk realized that in order for Congress to pass the health reform bill, the MoH needed evidence that the innovative Seguro Popular could work. In early 2001 the MoH launched the pilot phase of Seguro Popular in five states: Aguascalientes, Colima, Campeche, Jalisco and Tabasco. After an intense negotiation with the authorities of these states, the pilot phase of Seguro Popular was gradually introduced with emphasis on affiliating families in the lowest two quintiles of the income distribution. The initial goal was to affiliate 60,000 families by the end of 2002. However, by December 2001 the program had incorporated 295,000 families (approximately 1.5 million people) (63 Ortiz, Mauricio 2006).

The pilot phase proved that Seguro Popular had potential to work. However, in order for Seguro Popular to become a reality, two things needed to happen: 1. Congress had to pass the health reform bill and 2. The Minister of Finance had to approve a substantial increase in health public spending.

c. The Budget Negotiation

While trying addressing the technical aspects of Seguro Popular on one hand, Frenk also had to tackle the challenge of convincing key actors inside the Fox administration to appropriate sufficient funds for the program in the federal budget. In particular, he faced resistance from some groups within the Ministry of Finance (SHCP [17]). They were concerned that Mexico did not have enough fiscal space to accommodate the spending increase required to scale up Seguro Popular.

[17] SHCP - Secretaría de Hacienda y Crédito Público

Frenk relied again on the technical pillar and produced a series of rigorous economic studies performed by economists at MoH to persuade Minister of Finance Francisco Gil. The studies showed that, if allocated through Seguro Popular, the increased spending would be partially offset by efficiency gains. Frenk presented the case that the goal was not to spend more, but to spend better and target the population outside the coverage of the traditional health providers.

Frenk also invested some political capital in order to gain the support of SHCP. When Fox proposed a bill repealing the value-added tax exemption on medicines, Frenk supported it with the condition that the tax would be complemented with more investment in health services and in access to medications for the whole population. The bill was defeated in Congress, but SCHP reciprocated Frenk's public backing the bill and expressed willingness to work with MoH to increase health spending in the budget.

The final agreement between MoH and SCHP was to increase health spending by 1 percent of GDP each year for seven years. After this agreement, SCHP became a key ally in support of Health Reform despite initial opposition. SHCP was also favorable to the notion that Seguro Popular was a subsidy to the demand for health and that the new spending was going to be meticulously audited by the MoH. Another important aspect that influenced the decision of SCHP to increase health spending was that the pilot phase of Seguro Popular was successfully working in several states of Mexico.

d. *The Struggle for Mexico City*

The election of Fox in 2000 also strengthened the Party of the Democratic Revolution (PRD[18]), particularly in Mexico City[19] where Andres Manuel López Obrador was elected as head of government. The popular mayor of the country's capital was a staunch opponent of health reform and rallied his party to vote against it in Congress. The scrimmage with PRD did not end there. When the decision came to scale up Seguro Popular nationally, the Federal District refused to implement it. Since the left leaning PRD had a clearly pro-poor political platform, the MoH interpreted the conflict as a reflection of political differences with the right leaning PAN, rather than as opposition to Seguro Popular.

López Obrador argued that there was no need to implement Seguro Popular in the capital since the city government was already providing free health services and medications to the poor, but the MoH considered that the residents of the Federal District had the right to access the benefits of Seguro Popular. Therefore, it circumvented opposition by the local government and implemented the scheme using its own hospitals and institutes in Mexico City[20]. However, this would just provide a temporary solution, since the federal hospitals wouldn't be sufficient to provide services for large uninsured population of the city. However, under pressure from citizens of Mexico City, other PRD governors, López Obrador announced in late January 2005 that the Federal District would

[18] PRD – Partido de la Revolución Democrática.

[19] With over10 million inhabitants, Mexico City is home to around 10% of the population. Mexico City and the Federal District are used indistinctly

[20] The federal MoH operates several specialty hospitals in Mexico City commonly referred as Institutes, for example: The National Institute of Pediatrics and The National Institute of Cardiology.

implement Seguro Popular. Frenk recalls this as a major political achievement. Having it in all 31 states and the Federal District meant that Seguro Popular had become a national policy and not only a strategy of the federal government.

e. *Resistance from IMSS*

According to Frenk, negotiations with IMSS became one of the most difficult aspects of the reform process. Seguro Popular was perceived by various groups inside IMSS as a threat to the existing health system. Leading the resistance were General Director of IMSS, Santiago Levy and Secretary General of IMSS Union, Roberto Vega Galina[21]. While Vega Galina's opposition was based on political and ideological arguments, Levy's was built solely on economic and legal reasoning. He argued that Seguro Popular would incentivize informality and would promote the growth of informal salaried workers, a labor category considered illegal by Mexican labor laws.

Frenk presented four arguments against Levy's proposition. First, he argued that the program was targeting formal non salaried workers such as farmers, self-employed and unemployed and not only informal salaried workers. He pointed out that many farmers who were non-salaried workers already received transfers from federal programs such as Procampo and Oportunidades[22]. Second, informality had been growing already, so it was likely that labor regulations and other economic factors were more important determinants of informality. Third, the pilot had provided evidence that IMSS affiliation

[21] Roberto Vega Galina was also a congressman for PRI.

[22] Both programs were created by Levy during his tenure as Viceminister of Finance during the late 1990s.

had continued to grow in the states where Seguro Popular was tested. This meant that more workers were entering the formal workforce and that Seguro Popular was not providing incentives for workers to enter the informal sector to avoid paying IMSS contributions. Finally, Frenk appealed once again to the ethical pillar: even if Seguro Popular incentivized informality, access to health services was a human right and as such it should not be withheld from workers because of their employment status[23].

Neither IMSS nor the union were persuaded by the potential benefits of the health system, not even by the additional resources that it would represent for the agency as it would become the main health care provider for people insured by Seguro Popular. After intense negotiations, health reform was passed without support from IMSS.

f. Congress Passes Health Reform

After long sessions at the Chamber of Deputies and the Senate, the health reform was finally passed on April 30, 2003 and was signed into law by Fox on May 15. Seguro Popular would become a reality and by the end of 2006 it was being implemented nationally. However, as the program was expanded, some flaws in the design were uncovered and additional challenges would have to be met in order to realize the aspiration of achieving universal health coverage.

[23] Recent empirical research has challenged the notion that Seguro Popular creates incentives for informality (Heckman, et al, 2010). The authors conclude that the available evidence suggests that regulation and not social programs is the main cause of informality in the Mexican economy. While this research supports Frenk's position, the debate is far from closed and opposition on economic grounds remains a tough challenge for the program.

3. Calderón Takes the Baton

The next challenge of Seguro Popular was its survival. In 2006 Mexico had the tightest presidential election ever when Felipe Calderón from PAN defeated López Obrador from PRD by less than a percentage point.

When Calderón took office in December of 2006, he embraced the goal of universal health coverage and vowed to finish the work started by the Fox administration. However, Calderón and his team soon realized that in spite of the sweeping change brought by the health reform of 2003, several issues would need to be addressed in order to achieve this ambitious goal. In particular, some flaws of Seguro Popular would have to be fixed and its institutional framework would have to be strengthened.

Seguro Popular was working well in the 32 states and each day more families continued to be affiliated. However, essential operational issues remained unresolved when Chertorivsky was appointed Commissioner for Social Protection in Health.[24]

a. Prevention Policy

Chertorivsky found that the rules of operation[25] allocated 20 percent of the total budget assigned to states for health prevention measures. However, lack of a clear definition of prevention resulted in a wide array of activities that were not always targeted to Seguro Popular beneficiaries. For example, states in the south used the resources to spray fields

[24] The Commission for Social Protection in Health is an agency that administers Seguro Popular and is overseen by the Ministry of Health.

[25] Rules of Operation are a set of provisions setting out how to operate a program, with the aim OF achieving the expected levels of effectiveness, efficiency, equity and transparency.

for dengue fever prevention. Since fumigation benefited the general population, Seguro Popular was de facto subsidizing IMSS and ISSSTE. In other states, prevention resources were incorrectly used to pay wages. Moreover, the disparate prevention policies made monitoring and auditing a challenging task for the Commission.

In order to address this issue, one of the first actions Chertorivsky took upon his appointment was a change in the rules of operation whereby 1 percent of the budget allocated for prevention activities had to be allocated to a national strategy called "Preventive Check Up[26]". The strategy was designed to identify the population's epidemiological profile and improve planning of treatment availability. By preventing diseases, patients avoid unnecessary hardship and the government saves valuable resources that would be needed for curative treatment.

The Preventive Check Up strategy was being piloted in 18 of the 32 states by mid 2010. The Commission was in the process of introducing electronic health records that will be used to track health risks and would allow health authorities to devise early prevention strategies.

b. Transfer per Family vs. Transfer per Capita

Another challenge related to the financing of the program was the formula used to calculate resource allocation among states. The program allocated resources solely based on the number of families affiliated to the program. Therefore Seguro Popular failed to provide incentives for states to invest in improving the quality of services, one of the main

[26] Consulta Preventiva

goals of health reform. Furthermore, since resources from Seguro Popular became the main source of health funds, the Commission found that states were reporting single member families to artificially increase the resources transferred from the federal government.

On December 11, 2009, Congress passed a reform to the General Health Law to modify the resource allocation formula. The new formula allocates resources to states based on individuals, rather than families affiliated. This reform was considered a great victory by the Commission since it will allow funds to be allocated more equally and will eliminate incentives for states to misreport demographic information.

c. User Fees

When Frenk and his team designed Seguro Popular they foresaw user fees as a way to empower people. Paying a fee would prompt users to demand quality services from their health providers. However, they never considered the effect that the exemption of the fee for families in the lowest quintiles could have on state governments.

Chertorivsky found that the fee charged by Seguro Popular was providing incentives for states to report biased information about their affiliates. Seguro Popular is financed by federal funds that are matched by each state, but a symbolic fee is charged to beneficiaries upon affiliation. The fee is calculated based on the self-reported socioeconomic (SES) status of the family. For families in the two lowest quintiles of the socio-economic status index the fee is waived (78 Frenk, Julio 2009). As a result, potential affiliates are encouraged to underreport their income and other variables used in the SES index. States then report that most of the families fall in the lowest range of the SES distribution and therefore are

exempted from the fee. By doing this, states are able to affiliate families that might otherwise decline to participate in Seguro Popular because of the fee and avoid the costs involved in collecting and administering the fee.

Moreover states perceive the fee as an electoral cost since they are collecting money from potential voters. Politically the cost of the fee was higher than the benefits received by the resources collected. For these reasons, the Commission has been studying the possibility of eliminating the fee to resolve the problem. However, Chertorivsky is faced with a difficult dilemma. On one hand, eliminating the fee could result in Seguro Popular being perceived as a handout rather than a right and result in families feeling less empowered to demand quality services. On the other, eliminating the fee would result in the availability of more accurate data on the socioeconomic conditions of the affiliates (See Exhibit 7).

d. Portability [27]

One of the main issues that remained unresolved when Chertorivsky was appointed was the inability of affiliates to take their coverage with them when traveling or changing residence to a different state. This was a cumbersome restriction on the beneficiaries since sickness cannot be planned. Pregnant women were identified as the population mostly affected by the lack of portability of Seguro Popular[28]. The main concern was that a patient in need of urgent medical attention in a different state would have to pay for the services

[27] Portability of Seguro Popular means that the user can receive medical attention in any of the 32 states of Mexico.

[28] IMSS and ISSSTE, give to their users the option to receive medical attention in a state different to their state of residence.

out-of-pocket and this limited the ability of Seguro Popular to prevent catastrophic expenditures.

The root of the portability problem was the disagreement between states and health providers on the cost of medical treatments. The issue was that the benefit packages of the main health providers needed to converge in order for states to be able to pay for the services received by their resident in another state.

States, health care providers and Seguro Popular have not been able to agree on a common cost schedule. For example, Seguro Popular has not been able to agree with IMSS and ISSSTE on how much to charge for a similar medical procedure. States have been able to agree neither on how much to pay for the services nor how to make the transfer. States put the burden of solving the portability problem on the Commission, including the development of the administrative procedures needed to make payments across states.

On October 23, 2009 states, MoH and the Commission signed an agreement called Portability 32 by 32[29]. Through this scheme states have agreed to provide treatment to out-of-state Seguro Popular affiliates. However, they have not agreed on how to pay each other for medical services received by their residents. Since state public finance systems do not contemplate inter-state transfers, they have no way to register these transactions in the financial statements reported to SHCP and the state Congress auditing authorities.

[29] The oficial name of the Agreement is: "Convenio de colaboración y coordinación en materia de prestación de servicios médicos y compensación económica entre las 32 entidades federativas para la atención de los beneficiarios y afiliados al Seguro Popular".

Therefore, states have been providing medical services to non-residents, but have not been able to recoup the costs.

In addition to the inter-state transfer problem, states IMSS, ISSSTE and Seguro Popular have been unable to set a common benefit package to match costs of medical services and allow payments to flow between states and federal health care providers.

e. The "Management Trap"

Even though the Commission is a stand-alone agency, it depends financially and administratively on the Federal Ministry of Health. Every administrative decision, from purchasing to hiring, needs to be approved by the Ministry in order for Seguro Popular to operate. Even though Seguro Popular represents more than 70 percent of the total federal health budget, the bureaucratic relationship with the Ministry makes the day to day operation of the program very inefficient.

The same relationship is replicated in each state since state-level directors of Seguro Popular are appointed by and report to the state's Health Minister. This creates a conflict of interest because the state's Health Minister is at the same time responsible for the insurance provided by Seguro Popular and for the health care provided by the state's health services. As a result, state directors are in a trap since their mandate is to demand quality services for Seguro Popular affiliates, but they are subordinates of the authority responsible for providing them. In other words, the state's Minister of Health acts as both defendant and jury.

Moreover, the Commission does not have the formal authority to oversee the job of the state directors. If a state director is not achieving the annual goals or is misusing the federal resources allocated to the state, the Commissioner has no legal right to fire them. This was a concession by the federal government that was deemed necessary to make Seguro Popular more palatable for states during the negotiation of the 2003 health reform. However, Frenk and his team did not foresee the extent to which this arrangement would severely undermine the checks and balances of the system.

Solving this problem would require further changes to the General Health Law. The new reform would change the legal status of Seguro Popular from being dependent on MoH to being an autonomous agency similar to IMSS. However, the change would carry complex political economy implications since state Ministers of Health would lose control over the financial resources and personnel of Seguro Popular in their state.

f. Conversion from Federal to State Funds

The General Health Law that resulted from the 2003 reform specifies that once Seguro Popular resources enter a state, they become state funds. However, this is at odds with the Federal Tax Law that considers resources from the federal budget federal resources, even when transferred to a state. This contradiction needs to be resolved in order to fulfill the promise that the increased federal health spending would be meticulously monitored, audited and evaluated. However, this would require either a politically controversial reform to the General Health Law or an equally controversial legal challenge to force the Supreme Court to resolve the contradiction.

A related problem is that in order to maintain the affiliation rates needed to cover the population that remains uninsured, states have to match federal funds with resources from their own budgets. Unwillingness of state Ministers of Finance to allocate enough state funds has been a key constraint to the expansion of the program in some states.

In mid 2010, the Commission was exploring an alternative solution to give states an incentive to invest in service quality improvement and infrastructure expansion. Under this scheme, the Commission would link yearly federal transfers to a set of measures of the previous year's performance by the state. The challenge is to create comparable goals, but different metrics to measure the accomplishments of states. This would be necessary if equal distribution of resources among states is to be maintained. In other words, the Commission faces a difficult trade-off between boosting state performance and preventing poor states from falling into a vicious circle of less resources leading to underperformance leading to less resources.

4. The Future

When the health reform of 2003 was passed the federal government vowed that 50 million uninsured people would be covered through Seguro Popular by 2010. In February 2010 the program had reached 32.7 million, an impressive achievement, but still almost 20 million people short of the goal (79 Seguro Popular 2009)(See Exhibit 8).

The federal government re-stated the goal of reaching 50 million Seguro Popular affiliates by 2012, but significant hurdles still need to be surmounted in order to achieve it. However, even if this goal was achieved, the goal of universal health coverage would still face the test of whether Seguro Popular would be continued if a different party came to power in December of 2012.

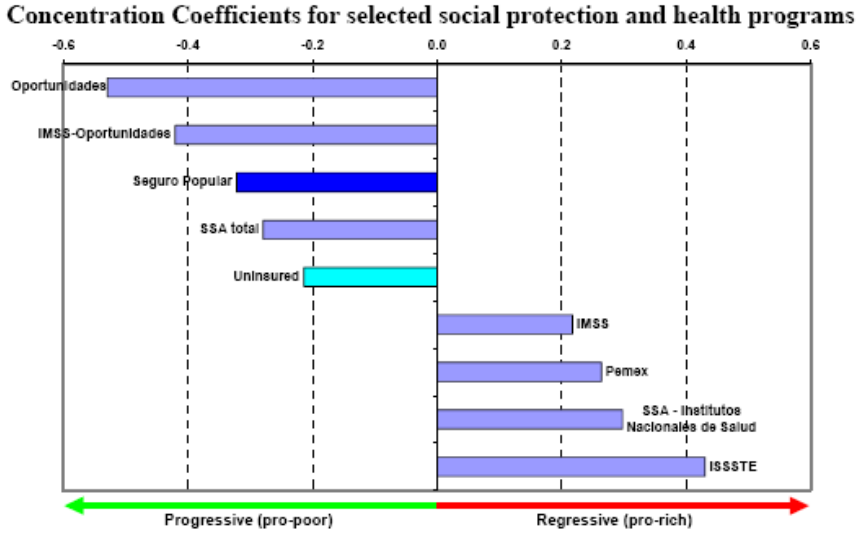
Seguro Popular has been considered a successful public policy throughout the years. It has been shown to reduce catastrophic expenses and affiliates report high levels of satisfaction. However, it is increasingly recognized that for Mexico to claim the achievement of universal health coverage, further reforms will be needed. Many government officials at both the state and federal level reckon that the next step would be to address the fragmentation of the health system and merge the health insurance functions of IMSS and ISSTE with Seguro Popular. This proposal would mean a single health insurance provider with the option for each individual to take their coverage to the health care provider of their choice. However, the technical and political obstacles for this are not trivial.

Chertorivsky felt a genuine sense of pride in being at the helm of Seguro Popular. The program was the flagship of a lengthy and painful reform process and it had made great strides in making the right to health coverage a reality for millions of Mexican poor. However, he knew that during his meeting with the President, he would not be able to provide definitive answers to several questions that remained unanswered. How to balance quality and equity when allocating funds to states? How to separate the functions of health insurance and health care provision? How to empower Seguro Popular beneficiaries without distorting the information they reported? How to make states more accountable without losing their political support? But most of all, Chertorivsky was at a loss on what to answer when the President asked whether Mexico would achieve universal health coverage by 2012.

EXHIBITS

Exhibit 1 - Regressive and Progressive Social Programs in Mexico

Figure 3: Coverage of formal Social Security is regressive, while coverage of poverty-targeted programs (e.g., *Oportunidades*, IMSS-*Oportunidades*, *Seguro Popular*) is progressive[6]

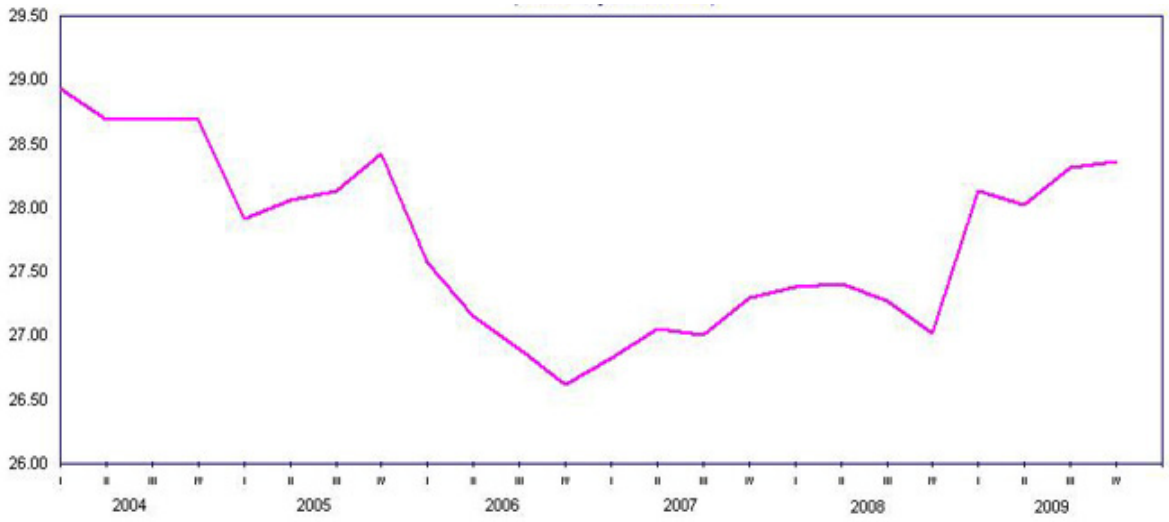


Source: Scott (2006), based on ENIGH 2004.

Source. World Bank (82 Masonandrew D. 2007)

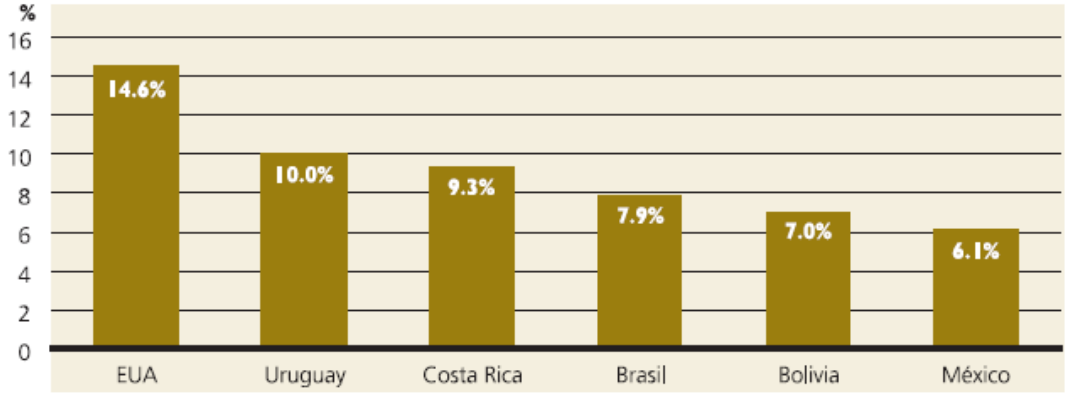
Exhibit 2 - Employment Rate in the Informal Sector (Percentage of labor force)

Seasonally adjusted quarterly national unemployment rate for the informal sector



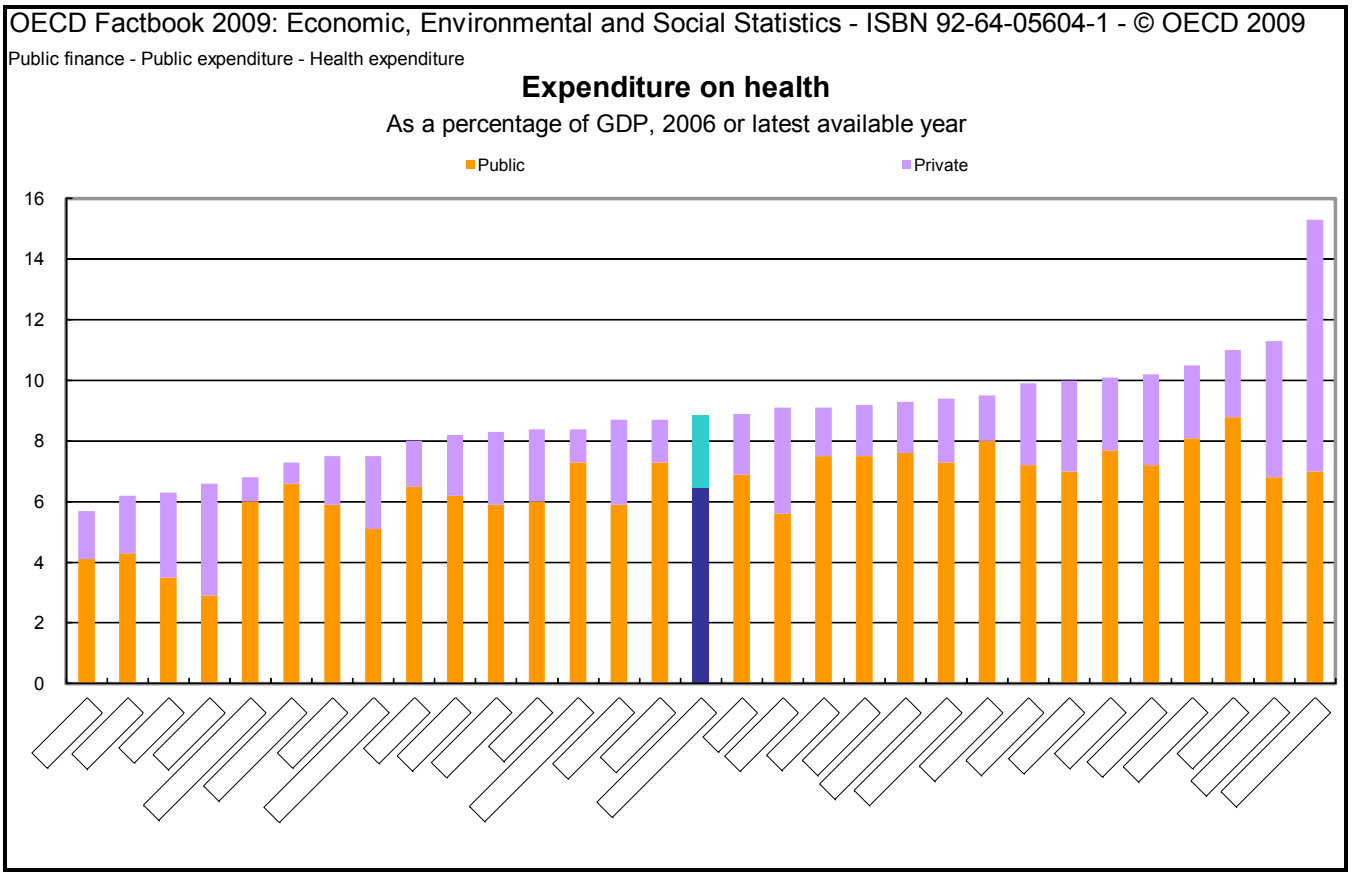
Source. Instituto Nacional de Estadística y Geografía, INEGI, 2009

Exhibit 3 - Health Spending as Percentage of GDP 2002



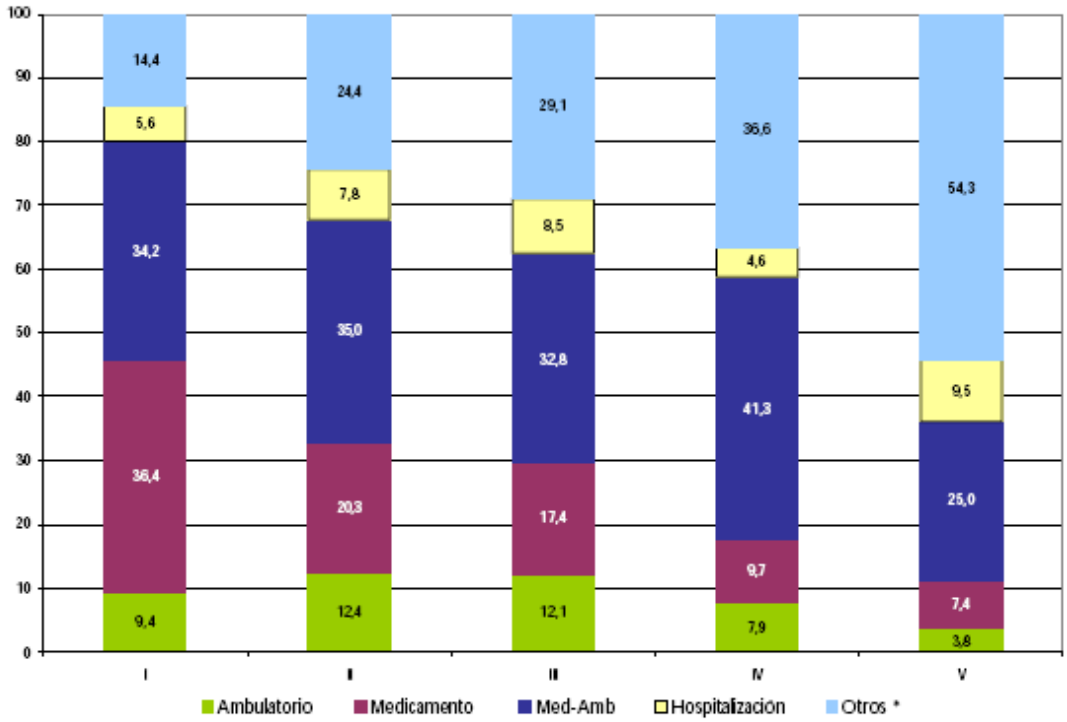
Source. Ministry of Health, Secretaría de Salud, Mexico.

Exhibit 4 - Expenditure on Health as a Percentage of GDP



Source: OECD Fact book: Economic, Environmental and Social Statistics

Exhibit 5 - Distribution of Catastrophic Spending among Quintiles (per capita)



Source: Secretaría de Salud, Mexico, 2003.

Exhibit 6 - Fairness of Financial Contribution

Annex Table 7 Fairness of financial contribution to health systems in all Member States, WHO index, estimates for 1997[a]

Rank	Member State	Index	Uncertainty interval
105 – 106	Georgia	*0.927*	*0.876 – 0.969*
107	Barbados	*0.926*	*0.890 – 0.957*
108 – 111	Croatia	*0.925*	*0.869 – 0.970*
108 – 111	Tunisia	*0.925*	*0.896 – 0.949*
108 – 111	Eritrea	*0.925*	*0.896 – 0.951*
108 – 111	Tonga	*0.925*	*0.896 – 0.950*
112 – 113	Tajikistan	*0.923*	*0.871 – 0.966*
112 – 113	Iran, Islamic Republic of	*0.923*	*0.890 – 0.951*
114	Burundi	*0.922*	*0.876 – 0.958*
115	Jamaica	0.921	0.861 – 0.923
116 – 120	Madagascar	*0.919*	*0.889 – 0.946*
116 – 120	Azerbaijan	*0.919*	*0.863 – 0.964*
116 – 120	Côte d'Ivoire	*0.919*	*0.879 – 0.952*
116 – 120	Antigua and Barbuda	*0.919*	*0.882 – 0.952*
116 – 120	The former Yugoslav Republic of Macedonia	*0.919*	*0.867 – 0.963*
121	Turkmenistan	*0.918*	*0.859 – 0.966*
122 – 123	Guinea-Bissau	*0.917*	*0.854 – 0.966*
122 – 123	Malaysia	*0.917*	*0.881 – 0.948*
124	Mauritius	*0.916*	*0.885 – 0.945*
125 – 127	Namibia	*0.915*	*0.884 – 0.944*
125 – 127	Egypt	*0.915*	*0.848 – 0.966*
125 – 127	Morocco	*0.915*	*0.878 – 0.945*
128 – 130	Thailand	0.913	0.913 – 0.926
128 – 130	Philippines	*0.913*	*0.880 – 0.943*
128 – 130	Uganda	*0.913*	*0.875 – 0.946*
131 – 133	Lithuania	*0.912*	*0.857 – 0.958*
131 – 133	Cyprus	*0.912*	*0.870 – 0.946*
131 – 133	Uzbekistan	*0.912*	*0.858 – 0.957*
134	Equatorial Guinea	*0.911*	*0.877 – 0.942*
135	Yemen	*0.910*	*0.870 – 0.944*
136 – 137	Somalia	*0.909*	*0.855 – 0.952*
136 – 137	Saint Kitts and Nevis	*0.909*	*0.867 – 0.945*
138 – 139	Bahamas	*0.906*	*0.863 – 0.944*
138 – 139	Ethiopia	*0.906*	*0.863 – 0.942*
140 – 141	Benin	*0.905*	*0.868 – 0.938*
140 – 141	Ukraine	*0.905*	*0.849 – 0.952*
142 – 143	Syrian Arab Republic	*0.904*	*0.856 – 0.944*
142 – 143	South Africa	*0.904*	*0.822 – 0.967*
144	Mexico	0.903	0.880 – 0.905
145	Estonia	*0.902*	*0.846 – 0.949*
146	Belize	*0.901*	*0.856 – 0.941*
147	Grenada	*0.900*	*0.853 – 0.940*
148	Republic of Moldova	*0.898*	*0.841 – 0.946*
149	Gambia	*0.897*	*0.854 – 0.935*
150 – 151	Mali	*0.896*	*0.846 – 0.940*
150 – 151	Poland	*0.896*	*0.838 – 0.946*
152	Togo	*0.895*	*0.853 – 0.933*
153	Mauritania	*0.893*	*0.840 – 0.938*
154	Dominican Republic	*0.892*	*0.842 – 0.934*
155	Zambia	0.891	0.881 – 0.917
156	Swaziland	*0.890*	*0.797 – 0.962*
157	Guatemala	*0.889*	*0.797 – 0.959*
158	Yugoslavia	*0.886*	*0.827 – 0.939*

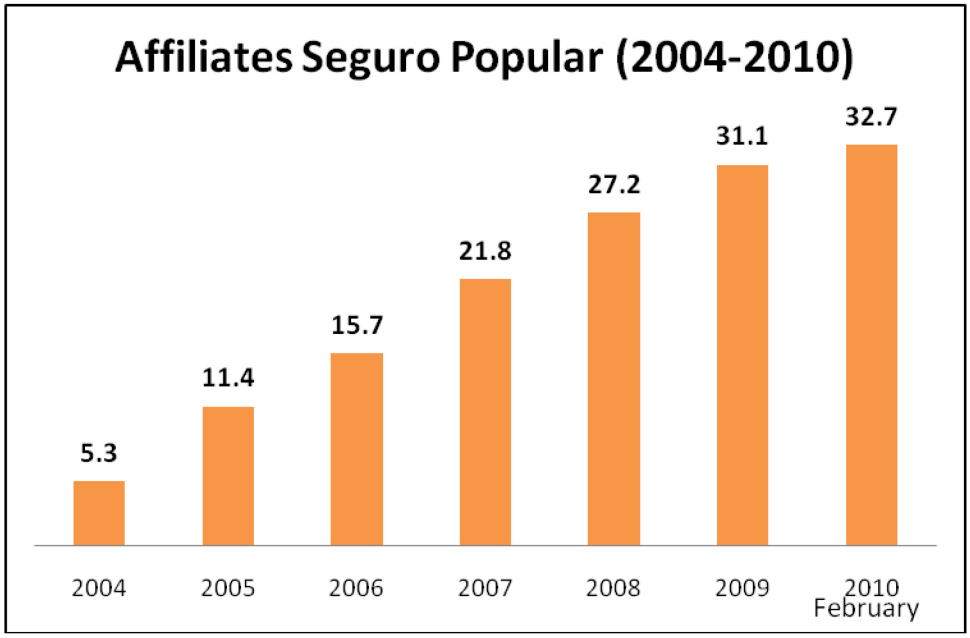
Source. World Health Organization Report 2000 (39 World Health Organization 2000)

Exhibit 7 - Family Fee per Income Deciles in 2009

CURRENT FEES	
Income Deciles	**Family Fee (In Pesos)**
I	0
II	0
II	713.96
IV	1,400.04
V	2,074.97
VI	2,833.56
VII	3,647.93
VIII	5,650.38
IX	7,518.97
X	11,378.86

Source. Comisión Nacional de Protección en Salud, SSA, 2010.

Exhibit 8 – Affiliates of Seguro Popular (per individual)



Source. Comisión Nacional de Protección en Salud, SSA, 2010.

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