



Mexican Healthcare System Challenges and Opportunities

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Mexico's healthcare system is underfunded and inadequately organized to meet the needs of its population in light of increasing longevity and the growing challenges created by the prevalence of noncommunicable diseases such as diabetes, obesity, heart disease, and cancer. The healthcare system has not changed substantially since the Health Ministry was established in 1943, yet the profile of Mexican patients has changed dramatically. Coverage has been expanded since that time and now all Mexicans have access to basic healthcare services, at least on paper. Yet the quality of said services, and in some cases access at all, varies considerably. Those who can do so rely on private services to augment, if not replace, services provided by the state institutions.

The Administration of President Enrique Peña Nieto, having implemented reforms across a wide range of sectors such as energy and telecommunications in the first two years of his term, is expected to turn to healthcare in 2015, especially in light of a campaign commitment to establish a Universal Health System. The challenges are substantial, but there appears to be a basic consensus about the changes required in order to strengthen Mexico's healthcare system and to improve its ability to provide services more appropriate to a population that is living longer and demanding better services.

This paper seeks to provide a brief review of the current system, followed by an analysis of the potential reforms to be implemented, their pitfalls and challenges, and finally some suggestions for

where the private sector could contribute to the reform efforts.

Historically Divided System

Since its inception, coverage under Mexico's public healthcare system has been based on employment status. Salaried or formal-sector workers are covered under one of two programs. The Mexican Social Security Institute (Instituto Mexicano del Seguro Social, or IMSS) was created in 1943 to provide healthcare coverage to private-sector, formal, and 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, or ISSSTE) was established to provide coverage for government employees and their families. Nonsalaried or informal-sector workers were excluded from formal social insurance schemes and the healthcare needs of this "residual" group were addressed by the Ministry of Health. The system was thus segmented—from its inception and through to the reform of 2003—between insured, formal, and salaried employees and their families with the right to social security, and the rest of the population (the self-employed, unemployed, nonsalaried and informal-sector workers, and those who do not work). The benefit package for those not covered by IMSS or ISSSTE was undefined and funded from a combination of federal funds and, to a lesser degree, state-level contributions, plus fees paid by patients and families at the point of service.

Prior to passage of the 2003 health reform program, approximately 40 percent of the population was covered by the IMSS, 7 percent by the ISSSTE, and no more than 2–3 percent by private health insurance. The remaining 50 percent of the population (roughly 50 million

people) lacked adequate access to public healthcare coverage. As a result, insurance coverage was regressive both among households and across states, with an overreliance on out-of-pocket spending to finance the health system. Further, impoverishing healthcare spending was common, particularly among families in the lowest income deciles.¹

In an effort to address the lack of adequate public healthcare coverage for persons not covered through a relationship with a formal-sector worker, President Vicente Fox proposed legislation that would achieve universal coverage. The government looked to offer subsidized, publicly provided health insurance to the 50 million Mexicans who were not covered by social security and were concentrated among the poor. In April 2003 the Congress approved a new insurance scheme, the Sistema de Protección Social en Salud (System for Social Protection in Health or SPSS and commonly referred to as “Seguro Popular”). The system went into operation on January 1, 2004 with the goal of achieving universal coverage by 2010. The Popular Health Insurance (PHI) was presented as the operational program of the new system.

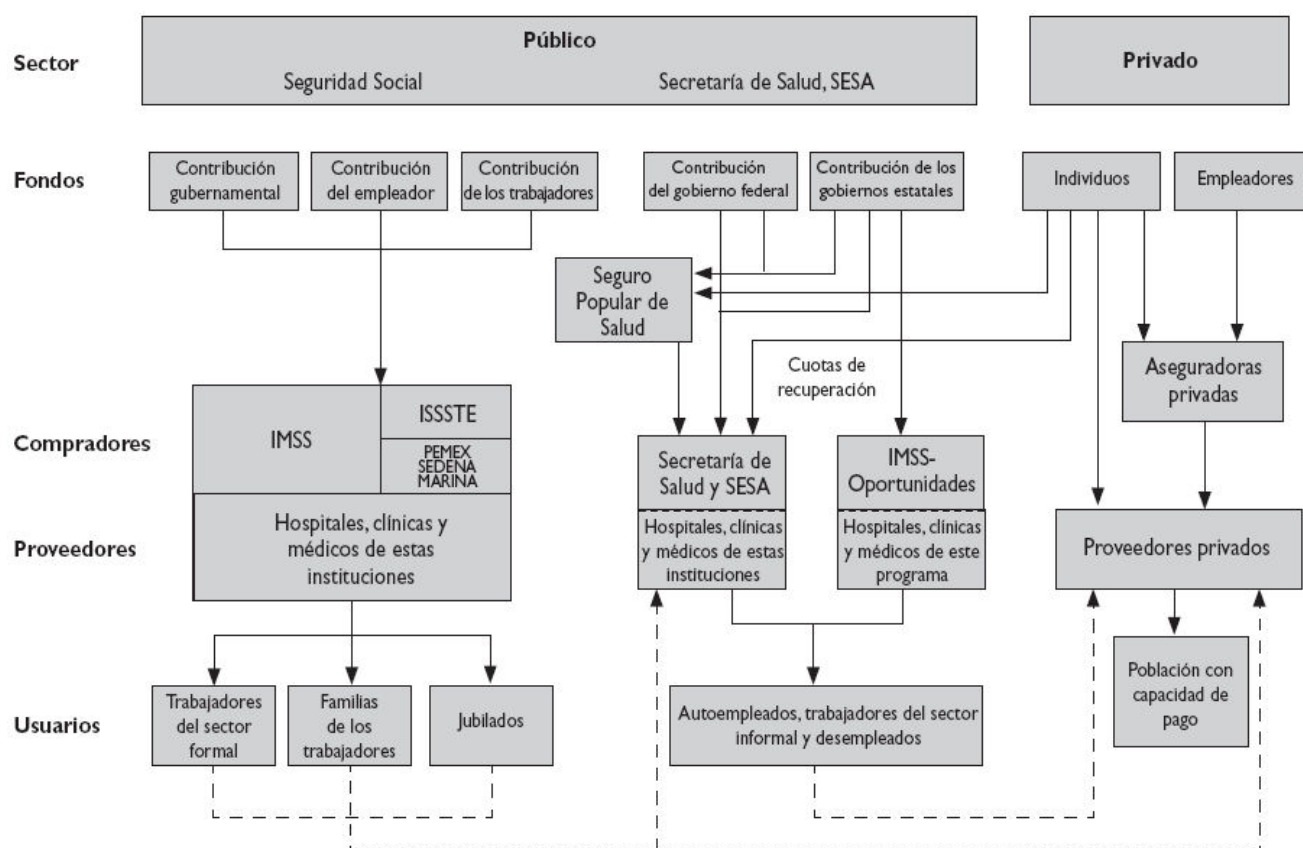
Current System

The healthcare system remains divided, with coverage based on employment. As noted above, formal, private-sector employees and their families are covered by IMSS, whose over 57 million beneficiaries make it one of the largest insurance providers in the Western Hemisphere. Public-sector employees and their families are covered by ISSSTE (roughly 12 million persons). The state oil company (PEMEX), the armed forces (SEDENA), and the

navy (SEMAR) have their own, smaller, institutions. The self-employed, unemployed, nonsalaried and informal-sector workers, and those who do not work are covered by one of several federal programs managed by the Ministry of Health, including the Seguro Popular program and IMSS-Oportunidades (a federally funded health service and conditional cash transfer program), which in total cover roughly 55 million persons. A small number of persons are eligible for coverage under multiple institutions, hence the number of beneficiaries exceeds the national population of 112 million. The system includes a private-sector component with insurance companies and service providers that maintain their own clinics and hospitals, including providers of alternative medicine.²

Mexico's Healthcare System³

The quality, scope, and approach to healthcare vary across the six institutions (IMSS, ISSSTE, Seguro Popular, PEMEX, SEDENA, and SEMAR). Each has its own independent network of doctors, clinics, hospitals, pharmacies, treatment centers, and unions. (In fact, the labor union of IMSS, SNTSS, is the second-largest union in Latin America.) The Mexican healthcare system does not allow for “portability,” which means that patients—except those experiencing obstetric emergencies (as of two years ago)—cannot access the facilities belonging to any institution except their own regardless of their proximity or the relative demand for the service. In other words, an ISSSTE beneficiary living next door to an IMSS pharmacy could not fill a covered prescription at that facility and would have to travel to the nearest ISSSTE pharmacy (or pay out of pocket at a retail pharmacy). Similarly, a kidney dialysis facility belonging to the Ministry of Health with excess capacity



(graphic copied from Gómez Dantés et al.)

cannot treat IMSS patients requiring dialysis even if the closest IMSS kidney dialysis facility lacks adequate capacity to treat all of its patients. The duplication of facilities in some areas and the shortage of facilities in others is a result of the independent nature of the systems and the absence of a single planning mechanism across the healthcare system. Of note, the main political parties in Congress have proposed an expansion of the conditions for which portability will be permitted to include the conditions that generate most of the catastrophic expenses, namely cardiovascular disease, diabetes, cancer, obesity, transplants, HIV-AIDS, leukemia, and hemophilia.

Each of the institutions maintains its own drug and device formularies and develops its own standards of care, which can vary considerably. Approvals for drugs and devices for use in Mexico are granted by the health regulator,

COFEPRIS, which reviews applications to confirm safety and efficacy for human use. These approvals apply to all of the institutions—each can purchase and use anything approved by COFEPRIS. The decision on whether to purchase a particular medicine or device, however, is made through the General Health Council (CSG). This council is an interinstitutional body charged with determining whether the member institutions should purchase products previously determined by COFEPRIS to be safe for use in Mexico based on a cost-benefit analysis. While each of the six institutions sits on the CSG and reviews the same information before voting to include or reject the product, in practice each institution conducts a second individual review and makes an independent decision regarding formulary inclusion. These decisions are often based on budgetary constraints. The net result, for the system, is that persons covered by different

institutions have access to different medicines and devices despite having equal right to access to healthcare under Article 4 of the Mexican Constitution.

Peña Nieto's Reform Plans

During his 2012 campaign, President Enrique Peña Nieto ran on a platform of instituting healthcare reform to establish a truly universal healthcare system that would provide security and stability for all citizens. The National Development Plan (Plan Nacional de Desarrollo 2013-2018) and the National Development Plan's Program for the Health Sector (Plan Nacional de Desarrollo 2013-2018 – Programa Sectorial de Salud), both issued in early 2013, included proposals to emphasize prevention—rather than focusing only on curative medicine—and the importance of ensuring that the poorest of the poor gain access to adequate healthcare. Specifically, the health program pledged to:

- Consolidate protective actions, health promotion, and disease prevention.
- Ensure effective access to quality healthcare.
- Reduce the risks affecting health of the population.
- Close existing gaps in health coverage between different social groups and regions of the country.
- Ensure the generation and effective use of health resources.
- Advance the construction of the National System of Universal Health under the stewardship of the Ministry of Health.

Peña Nieto proposed to strengthen the authority of the Ministry of Health and to promote stronger cooperation between the state-run medical programs and private institutions. He favored strengthening the regulation of healthcare

facilities, implementing stringent quality standards, supporting the approach of prevention and promotion of healthy living, and improving the planning and management of available resources.

For those living in extreme poverty, Peña Nieto pledged to intensify training and supervision of maternal and prenatal caregivers, to augment vaccination marketing campaigns within poverty-stricken areas, and to focus on prevention, diagnosis and treatment of diseases, as well as a comprehensive strategy for combating epidemics and malnutrition. The health program also includes a commitment to the development and application of a mobile medical units program, with specific emphasis on vulnerable areas of Mexico.

The incidence of noncommunicable diseases (NCDs) has increased in Mexico, and the country now has one of the highest diabetes rates in the world. Peña Nieto's National Development Plan emphasized promotion of state-led disease prevention programs, which could reduce the burden of morbidity and mortality of chronic noncommunicable diseases, mainly diabetes and hypertension. Obesity is another area in which Mexico has the unfortunate distinction of being a world leader, even surpassing U.S. rates. This led the Health Ministry to launch the "National Strategy for the Prevention and Control of Overweight, Obesity and Diabetes" in 2013. In addition, heart disease and cancer rates have also grown—partly as a result of longer lifespans stemming from improvements in the quality of life over the past decades. Average life expectancy has increased from 70 years in 1990 to 75 years in 2011.⁴ While increased lifespans are good for individuals and for society, they do tend to place additional demands on the healthcare system

and on its budget. Mexico currently spends roughly 6.2% of its budget on healthcare, one of the lowest rates in the OECD and well below the average of 9.6%.⁵ This low rate of government spending places a greater burden on out-of-pocket expenditure. At present, roughly 45% of healthcare expenditures in Mexico are paid out of pocket.⁶ As a result, long-term illness can be catastrophic for the lower and even middle classes.

Reform of the system, therefore, must both improve the manner in which existing resources are spent and increase the total amount available. In addition, and consistent with Peña Nieto's National Development Plan, the focus of healthcare must move from curative treatment to prevention. There is broad consensus within the healthcare community in Mexico of these broad needs; however, to date the government has taken limited steps to address these objectives.

One concrete proposal related to improving the health of Mexican citizens was the imposition of new sales taxes on sugared beverages and foods considered to be excessively high in calories (the so-called "junk food" tax), with the proceeds from the tax to be directed to improvements in healthcare. The tax proposal was adopted in December 2013 along with a number of other tax reform measures; however, the funds generated were not earmarked for healthcare. Even if the funds were not directed toward healthcare, one might have expected that the tax increase would have led to a decrease in soda consumption. Recent reports, however, indicate that consumption has not declined dramatically.⁷ Although the reasons for this are not entirely clear, soft drinks are often consumed in areas lacking access to clean water. This suggests that a price increase would not reduce consumption, but rather shift

consumption to less expensive alternatives such as local brands or to reductions in other expenditures. Although early in implementation, the tax increase has not yet contributed to the Administration's stated goal of improving the health of the population and has created tension between the private sector and the government.

The Peña Nieto Administration has sought to improve the efficiency of the drug procurement process. In October 2014, IMSS coordinated the "Licitación del Año" or "Sale of the Year" with the participation of all of the federal healthcare institutions as well as 17 state health ministries, by far the largest number to date. Roughly 90 million Mexican citizens were covered by this reverse auction-style procurement in which bidders offer steadily lower prices in order to obtain the contract, with a total expenditure of \$3.7 billion. In addition, IMSS took steps to guarantee the transparency, competitiveness, and certainty of the process. It is possible that continued expansion of the Licitación will promote greater consistency across the healthcare system in terms of the availability of medicines while ensuring the most efficient use of the drug budget.

An additional healthcare-related initiative undertaken by the Peña Nieto Administration is greater promotion of medical tourism, which has been identified as a priority for ProMexico, the export promotion/investment attraction arm of the Secretary of Economy. Mexico receives medical tourists, primarily from the United States, who are seeking treatment for conditions not covered by U.S. insurance—such as cosmetic surgery, dental procedures, and weight-loss surgery—or for access to treatments not approved by the FDA. However, the government aspires to attract a different type of patient—one seeking care for conditions that are

covered by insurance but for which there could be considerable savings, and considerable advantages, to having the procedures performed in Mexico. ProMexico estimates that the cost of treatment in Mexico can be anywhere from 36% to 89% less expensive than in the United States for procedures ranging from dental implants to heart valve replacement surgery.⁸ ProMexico has produced studies that describe the potential cost savings and identify the hospitals in Mexico that have received international certifications. The Secretary of Tourism has also focused considerable attention on this area; however, it is unclear to date whether these efforts have generated increased medical tourism, due to lingering concerns about public safety and the overall quality of care.

Earlier this month the chair of the Chamber of Deputies' Healthcare Commission announced that the Peña Nieto Administration will present a reform proposal when the Congress reconvenes in February. While the proposal has not yet been published, public sources suggest it will promote universal care and institution of "portability" among the existing institutions.

Challenges to Reform

The divided nature of the Mexican healthcare system makes reform a daunting task. In addition to making changes, for example, in the emphasis from curative to preventative medicine, reform will require consolidating large bureaucratic and independent agencies. One of the initial steps that has often been proposed to begin a consolidation process is implementation of "portability," which would help address the inefficiencies that have arisen due to the lack of centralized planning such as a lack of treatment in some areas and a surplus in others or delays in gaining access to treatment due to

oversubscription in some areas. Such an approach could provide an effective means of evaluating the quality of care between institutions as well as reducing inefficiencies. If patients can choose where to have treatment, then a facility that remains oversubscribed would indicate a perception (real or imagined) among patients of higher quality. A facility that is underutilized, conversely, may need remedial attention to address perceived (or real) deficiencies. Nevertheless, portability will not be easily implemented. There are at least five main challenges that would have to be addressed to create an efficient and effective system in which beneficiaries would be able to choose where they wanted to be treated.

Reimbursement: Allowing the patient to choose his or her treatment facility will require development of a system for interinstitutional transfers as well as negotiation on the appropriate rate to be paid for a given service or procedure. Such a "formulary" would have to take into account the variations in costs across the country and the differences in overhead and other institutional costs. One can imagine, for example, that IMSS with over 50 million patients might be able to charge less for some procedures than the much smaller ISSSTE, or that the smaller institutions (ISSSTE, SEDENA, PEMEX) could find it more efficient to outsource certain treatments and procedures to their larger counterparts. All of these options would potentially create efficiencies and greater patient choice, but none can be adopted quickly. Rather, the institutions will have to develop a system to account for the cross-institution (or "out of network") treatment that will likely require initial expenditures to upgrade IT systems and develop interconnectivity to exchange information and transfer payments.⁹

Health Records: Not only would portability require the institutions to establish mechanisms to reimburse for treatment, but they would also need to exchange patient records in order to ensure that physicians can properly treat patients, avoid harmful drug interactions, and remove the potential for abuses of the system (such as patients seeking multiple prescriptions). The development of Health IT systems is complex and encompasses technological issues as well as potentially raising patient privacy concerns. Regrettably, even within the institutions data collection and retrieval are limited and inconsistent, and the use of electronic records rare. Without developing a comprehensive method of exchanging information among the institutions, each will have to rely on patients themselves to provide information or expend valuable resources duplicating information already available (in theory, if not practice) within the patient's responsible institution.

Standards of Care: Because the institutions have developed independently, and have made independent decisions regarding which medicines and treatment options to use, the systems provide different types of care, even for the same illness. Implementation of portability will require some sort of reconciliation of, or training regarding, these differing standards in order to ensure that beneficiaries of a given institution can receive equal care regardless of which institution's facilities they use. Absent reconciliation of how a condition should be treated, reimbursement may be more complicated among institutions. Further, if a patient has been treated with a medication or device not found on another institution's formulary, it is possible that the facility would not be adequately prepared to provide treatment or

not fully appreciate potential drug interactions or complications related to the use of innovative devices or medications, especially in the area of biologics. Harmonization of the technical and personal quality of health services is one of the objectives of the National Development Plan, presumably in recognition of the varying standards across the healthcare system.

Labor: A fourth major challenge to portability relates to the employees of the institutions, each of which negotiates its employment contract independently. Portability will, in all probability, drive patients toward or away from certain facilities. Increases in workload may create labor strife, while decreases in workload in underperforming institutions could generate pressure to reassign personnel to other facilities or to make other alterations or reductions in work schedules that the unions may not accept. In the extreme, portability could even allow for consolidation and the closing of underutilized facilities, which, while advantageous from the perspective of the healthcare system at large, could simultaneously generate opposition among local politicians who view delivery of public facilities as a tangible demonstration of their contribution to their constituents.

Resources: Simply put, portability will require initial expenditures from a system that is already underfunded. Development of integrated systems to track and manage payments across the institutions and to permit the exchange of health records, while ultimately cost-saving, will initially require new allocations. The differences of standards of care may require additional training of personnel to ensure that portability does not perpetuate differences among institutions but rather reduces them. While not the primary focus of this paper, one cannot review the Mexican healthcare system without

taking note of the special budgetary challenges faced by IMSS, which in addition to providing healthcare services for its beneficiaries also administers the formal-sector pension system. Like many other such systems, IMSS faces a funding shortfall due to comparatively early retirement eligibility and rising longevity. Since pensions are guaranteed, IMSS has no choice but to redirect resources from the healthcare side of its budget to the pension side. As a result, IMSS faces an even greater funding challenge than its counterpart institutions. Reform of the pension system, including dividing IMSS into separate institutions with distinct responsibilities and funding, is one potential solution, though with its own set of challenges.

Opportunities

Reimbursement and Health IT technology and implementation. Should the Peña Nieto Administration decide to embark on an effort to establish portability, there would be ample opportunities for private-sector firms to present offers for services to governmental institutions related to payment mechanisms and medical record development and access. For example, it is unlikely that the current practice of meeting periodically to reconcile obstetric charges among the institutions would be adequate to address the full range of services. Rather, the institutions will likely need to develop an agreed-upon electronic solution to provide more timely reconciliation of what would be a far greater number of transactions. The back-room operations required for reconciling claims across numerous providers and insurance companies in the United States will have led to development of important efficiencies and economies of scale that may be replicable in Mexico. On the electronic records side, and as noted previously,

portability will require enhanced collection and sharing of electronic patient records that will raise similar concerns to those identified in the United States. Solutions providers that can help healthcare providers protect sensitive information while ensuring real-time access across the institutions may find a number of interested customers that will be responding to patient demand for privacy.

Medical tourism. The dramatic cost differences for some procedures between Mexico and the United States and the emphasis on rehabilitative care following surgery give Mexico important comparative advantages over the United States. In addition, as the Affordable Care Act is implemented, an increasing number of employers will seek affordable options for employee healthcare. A medical tourism program developed in partnership between an insurer, an employer, and a Mexican hospital could prove to be an effective way to ensure adequate, affordable treatment. In addition, such a program can provide important training and capacity building for the Mexican institution—experience that can then be made available to Mexican patients as well as foreigners. Two major impediments to increased medical tourism in Mexico are concerns over public safety (not limited to medical tourism, of course) and concerns regarding assurances of quality of care in Mexico and then following return to the United States. Increasing the consistency of quality of care among Mexican hospitals, perhaps through partnerships with U.S. teaching hospitals, and/or providing guidance on how to meet international standards where desired or appropriate are two additional areas that could generate opportunities and produce positive benefits for all parties.

Creative procurement. Combined purchasing across the institutions, such as through the “Licitación del Año,” with its reverse-auction format, can be an effective means to exploit economies of scale. If combined with efforts to standardize care across institutions, this approach should make an important contribution toward equal care for all Mexicans regardless of the source of their income. From the perspective of producers and distributors of these products, the combined purchase will necessitate more creative bids, including risk sharing and perhaps integrated approaches that combine product and delivery. It is important to note, however, that most of the funds dedicated to the Licitación were used to purchase generic medicines. As a result, Mexican patients relying on the state will continue to be denied access to the innovative medicines and devices that have been approved by COFEPRIS in the past few years. Ideally, the Mexican government would use some of the savings generated by the combined purchase of basic medicines to create space in the budget for innovative devices and medicines that could, in the long run, prove more cost-effective.

Regulatory convergence. The National Development Plan calls for the promotion of international health cooperation. The President seeks to strengthen surveillance of epidemiological emergencies, comply with international treaties on human health rights framework, and encourage new patterns of international cooperation in public health to strengthen local and regional capacity. While much of this remains rhetorical, the Peña Nieto Administration, under the leadership of COFEPRIS Federal Commissioner Mikel Arriola, has embarked on an effort within the Pacific Alliance (PA) to establish a common regulatory

system among the four member countries (Mexico, Colombia, Peru, and Chile). As this effort reaches full implementation, it will create a single market of roughly 200 million people. If the agreed regulations match international standards and best practices, the result should be more rapid introduction of new, innovative technologies into Mexico and its fellow PA members. While not directly related to healthcare reform in Mexico, efforts to bring more innovation to Mexico more quickly will directly impact the efficiency of the healthcare budget.

Conclusion

The fractured Mexican healthcare system provides treatment for roughly 110 million patients who are living longer and will continue to demand better care as their country continues to grow economically. The current divided system is inadequate to both address the growing needs and effectively respond to changes in the demographic composition of the country. Mexico is currently in the advantageous demographic bubble when its working population exceeds the size of the nonworking population. This moment in the demographic timeline is the ideal time to make systemic changes that can proactively anticipate the needs of the future population. Doing so will require the kind of political leadership and national consensus seen in the recent reform of the energy sector. When the Peña Nieto Administration embarks on reform, the opportunities for public-private partnerships and foreign investment and participation will be considerable, particularly for companies with appropriate guidance and a willingness to explore innovative approaches.

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⁴ “Health Profile: Mexico.” World Health Rankings. World Life Expectancy, n.d. Web. <<http://www.worldlifeexpectancy.com/country-health-profile/mexico>>.

⁵ Study conducted by IMS Health for the Asociación Mexicana de Industrias de Investigación Farmacéutica (AMIIF), January 2014.

⁶ Instituto Nacional De Estadística Y Geografía. “Cuenta Satélite Del Sector Salud De México, 2012.” Boletín De Prensa 256/14 (n.d.): n. pag. 5 June 2014. Web. <<http://www.inegi.org.mx/inegi/contenidos/espanol/prensa/boletines/boletin/comunicados/especiales/2014/junio/comunica1.pdf>>

⁷ “Survey Shows Mexicans Drinking Less Soda After Tax; Majority of Participants Now Relating Sugary Drinks to Health Problems,” *Wall Street Journal* (WSJ.com edition), October 13, 2014.

⁸ “Health Tourism,” 2013 report prepared by ProMexico.

⁹ It should be noted that the institutions already meet periodically to reconcile accounts for treatment of obstetric emergencies based on a fixed cost per treatment according to Under-Secretary of Health Eduardo González-Pier (interview published in *El Universal*, September 1, 2014).

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