Granting Universal Access to Health Care:
The experience of the Mexico City Government.

A case study commissioned by the Health Systems Knowledge Network

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Background to the Health Systems Knowledge Network

The Health Systems Knowledge Network was appointed by the WHO Commission on the Social Determinants of Health from September 2005 to March 2007. It was made up of 14 policy-makers, academics and members of civil society from all around the world, each with his or her own area of expertise. The network engaged with other components of the Commission (see http://www.who.int/social_determinants/map/en) and also commissioned a number of systematic reviews and case studies (see www.wits.ac.za/chp/).

The Centre for Health Policy led the consortium appointed as the organisational hub of the network. The other consortium partners were EQUINET, a Southern and Eastern African network devoted to promoting health equity (www.equinetafrica.org), and the Health Policy Unit of the London School of Hygiene in the United Kingdom (www.lshtm.ac.uk/hpu). The Commission itself is a global strategic mechanism to improve equity in health and health care through action on the social determinants of health at global, regional and country level.
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Introduction

In Mexico health protection is a constitutional right since 1983 which should mean that it is granted to all individuals, i.e. it is a universal right. However there are two serious shortages to the compliance with this right. One is that the General Health Law, that regulates the Constitution in this aspect, stipulates various forms to accede to health care: through public social security; through paying part or all services according to income and; starting in 2004, through the affiliation to the System of Social Protection in Health (“Popular Insurance”). The other is that the public health system is segmented between the federal Ministry of Health and decentralized state Secretariats of Health on the one hand and, on the other, two large public social security institutes\(^1\), one for state employees including their families and the other for private sector workers and their families.

In practice this translates into deep inequities in access to health care determined by the position in the labor force, individual economical resources and place of residence. This is so because those with a formal job and their families (about 50 percent of the population) have free health services offered by the social security institutes at their own integrated health facilities with salaried staff and a geographic distribution fairly congruent with the number of insured persons. This contrasts sharply with the conditions of access for the uninsured population that faces a variety of obstacles to accede to required health care. The main one is economical since it has to pay for almost all medical services and drugs which frequently mean that necessary care is postponed among the poor. Furthermore the geographical distribution of health care facilities and of health budgets is very unfavorable to poor states and regions (Programa Nacional de Salud, 2001), which means that those at higher risk have less access to adequate services.

Finally it should be mentioned that private services, which operate according to market principles\(^2\), play a role in medical care but provide only about twenty percent of all hospital care and surgeries provided in the country according to

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1 The main two social security institutes are the Mexican Social Security Institute (IMSS) and the Institute of Security and Social Services for State Workers (ISSSTE) but the state oil company and the armed forces also have their own institutes.

2 There are very few NGOs or religious which operate medical services in Mexico.
Furthermore, 85 percent of the private hospitals have less than 15 beds and do not comply with a minimum of quality standards. However, during the last decade some large hospital enterprises have entered into the market and are generally linked to private health insurance (Laurell, 2001).

**The Mexican health reform**

Mexico has experienced a stepwise main stream Health Reform modeled on the World Bank (World Bank, 1993) blueprint since 1983. The federal Ministry of Health, responsible for most public health actions and for providing health care to the uninsured population, decentralized the operation of public health programs and health care facilities to the state level. The federal Ministry preserves a regulatory role, controls the federal health budget and distributes it among state governments, and operates the large specialized health institutes located in Mexico City. The decentralization was not accompanied with a strategic plan to strengthen health infrastructure nor with an increase in the health budget for these services that represents a scarce 0.9 percent of GNP as compared to the 1.54 percent of GNP corresponding to public social security health budget. However, a free Basic Health Package of mainly preventive services and common childhood diseases was introduced but the remaining services are paid for and the criteria of means testing were tightened.

In 2003 a voluntary health insurance for the population that is not covered by the public social security institutes, i.e. does not have a formal job. This insurance covers a defined health package of about 100 interventions, with a means tested premium and predetermined federal and local government subsidies, was legislated (Diario Oficial de la Federación, 2003). This insurance will gradually be applied over a period of seven years affiliating no more than 14.3 per cent of the eligible population annually, starting in 2004. It is argued that this new insurance and its fresh economic resources would strengthen the services for the population lacking social security coverage. However, in reality it has provoked a new segment

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4 Decentralization occurred stepwise and was initiated in 1985 and concluded in 1997.
5 Data from the budget approved by Congress for 2006.
in the public health care system since the new resources and a significant part of the regular budget are mainly used to attend those enrolled which means that other users at the same facilities are discriminated. It is also troublesome that the financing agency of the Popular insurance has started to contract private services deviating the new resources from the public system despite a prohibition in the law.

The reform process has also reached the Social Security Institute for private sector workers with a mayor privatization reform of the pension system in 1995. This reform has impacted negatively on the health services of the Institute (Laurell, 1999) because the cross subsidy from the pension funds to the health fund was abolished. Furthermore the employer contribution to the health fund was reduced and despite the increase of the state subsidy there is a chronic deficit in the health fund which has resulted in a deterioration of services mainly because of the sustained decrease in salaries and stagnation in new affiliations with a concurrent ageing of the insured. However the attempts to privatize the provision of services have been resisted by unions.

It is with this background that the experience of the Mexico City government health policy should be analyzed since it is different from the national one. The main objective of the new policy is to grant access for the uninsured to all available government health care services that, together with those of social security, would grant universal coverage in Mexico City. This purpose also requires strengthening a variety of aspects of the deteriorated public services in order to provide an adequate health care and regain the trust of citizens.

The general context of the Mexico City government’s health policy
A crucial element for the understanding of the Mexico City government’s (MCG) health policy is that a broad progressive social policy is the number one priority on the government agenda together with public security. The concepts that guide the social policy are those of: social rights, trending to universalism but with an initial territorial targeting on the poor areas of the city; progressive income redistribution and; with a massive application. The reasons for territorial targeting are to use

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6 In this paper Mexico City refers to the Federal District with about 8.8 million inhabitants and does not include the surrounding municipalities that belong to the State of Mexico with a population of about 12 million.
incontrovertible criteria; avoid individual means-testing to diminish stigma and administrative expenditures; eliminate discretional decisions that facilitate political patronage and; avoid a division in the community.

The global social policy has its best expression in the Integrated Territorial Social Program that comprises: housing and neighborhood renewal; scholarships for children of single mothers; breakfasts in public schools; compensation for the increased milk price; economic aid for the disabled; scholarships for job training; micro credits for household production; funds to peasants for the protection of remaining rural areas and; a pension and health care for senior citizens. Most program components have been applied according to the poverty incidence of each city section, to attend preferentially those classified as of very high or high marginality. The beneficiaries of this program are close to one million persons (excluding the urban renewal program) with a budget of 580 million US dollars in 2005. These massive programs have a positive impact on living conditions in the city which in turn most likely has had an impact on health.

It should be mentioned that local health secretariat is in charge of the old age pension that started as a program in 2001 and reached universal coverage in 2002. The corresponding law was approved by the local Congress in 2003 which means that this new social right was established in the city for the first time in Mexico. Before this law only workers who had paid a contribution for at least 1,250 weeks to the pension fund of a social security institute were entitled to an old age pension.

The health policy
The Mexico City government’s health policy is based on the same values and principals as the general social policy. Following the premise that no public action can be defined independently of social values, MCG explicitly holds that all men and women are intrinsically of equal value; hence governments have the obligation to honor and protect alike the life of all. The concrete demonstration of this is to approach health as a social right and, thereby, as a responsibility of the
government as the guardian of the common interest. As was mention above the right to health protection is a constitutional right in all Mexico but it is not clearly stated that the state is obliged to grant it universally to all. The crucial difference between the health policies of the Mexico City and of the federal governments is precisely the recognition of the former that it should be an entitlement of all citizens granted by the state i.e. a demandable right. It also means that any kind of discrimination be it against women, the poor, sexual preference or ethnic minorities, is unacceptable.

The health policy that is implemented in Mexico City corresponds to the health policy proposed by progressive forces, and particularly by the left Party of the Democratic Revolution, as an alternative to the neoliberal health policy that has been dominant in the country since the ‘80ies.

In order to understand the strategy undertaken by the local government to attain this purpose it is necessary to summarize the conditions, limitations and problems faced at the beginning of the present Mexico City administration. First it should be kept in mind that about 60 per cent of households are beneficiaries of one of the public social security institutes and do have free access to all required health care services. To grant universal access in the city it is then the responsibility of MCG to offer health services at its own health care facilities to the uninsured population, i.e. to the additional 40 per cent. Increased access involves two important issues; on the one hand, it is part of basic “life security” (Hammer and Berman, 1995) and, on the other, facilitates regular contact with health services which is a condition for much of preventive care including timely care with the avoidance of complications and preventable deaths.

However the city’s health care services were insufficient to cover efficiently this population and had additionally suffered an important deterioration for almost two decades both in material and institutional aspects mainly due to a chronic lack of resources with a negative impact primarily on the opportunity y quality of medical care. Specific public health actions such as epidemiological surveillance, vaccination, preventive maternal and child care, basic sanitation, etcetera, were fairly well functioning but general health regulation had not been transferred to the local government by the federation.
This situation led the MCG to adopt five main strategies in its six year health plan\(^8\): i) the removal the economical obstacle to access through the Program of Free Health Services and Drugs (PFHSD); ii) the enlargement and institutional strengthening of health care services based on criteria of health needs; iii) a new health care model with an emphasis on health education, promotion, prevention, early detection and control of chronic diseases; iv) a substantial and sustained increase in the health budget with fiscal resources and; v) the intensification of popular participation and social control over health care services.

The Program of Free Health Services and Drugs

The main barrier to access to health care services for the uninsured is the economical obstacle since the geographical one is relative given the small territory of the city and a reasonable communication system. The problems of bureaucratic and cultural obstacles will be treated below since they have to do with institutional functioning and differential information.

The Program of Free Health Services and Drugs (PFHSD) was started in July of 2001. Initially it was only promoted at MCG health centers and hospitals in order to avoid a sudden overload of service demand and to manage a gradual and solid implementation. The eligible population, i.e. that which does not belong to any public social security system and lives permanently in Mexico City, is an estimated 850,000 to 900,000 families or 3.4 to 3.6 million persons\(^9\). The requirements to get enrolled in the program are to demonstrate residency in Mexico City and to lack the protection of a public social security institute. Once inscribed the family gets a credential that gives access to all services offered at the 215 health centers and 27 hospitals of the MCG and the prescribed drugs.

It was a deliberate policy decision not to define a "package" of free services and drugs but to offer all available services and the authorized drugs to the program population as a principle of equity, understood as equal access to existing services facing the same need. Apart from the ethical principle not to deny existing services to patients for economic reasons, this policy has many advantages in

\(^8\) Programa de Salud al 2006 del Gobierno del Distrito Federal see [www.salud.df.gob.mx](http://www.salud.df.gob.mx)

\(^9\) It is not possible to have a more exact estimation given the unstable labour market.
terms of efficacy and efficiency. Since it obeys to the logic of needs it avoids fractures in the continuum of health care interventions unlike the “package” approach based on the logic of cost-effectiveness which starts by pricing each intervention.

It also tends to increase a regular user contact with health care services and a timely provision of the required treatment given that all services are free and a number of services are offered which means that people now attend health facilities not just for emergency care. This is important since experience in Mexico City shows that health is a low priority in poor families’ expenditure strategy until a disease is perceived as serious or very serious. This coincides with other studies on the impact of user fees (Arhin-Tenkorang, 2001, Fiedler and Suazo, 2002). The responsibility to choose what services to provide and organize an adequate care then should be a responsibility of the government and not an economically determined choice of patients that delays treatment.

The progress of the PFHSD has been satisfactory. By July of 2006 840,000 or about 94 per cent of the eligible families had enrolled in the program. However it should be mentioned that there is a tendency not register all family members which probably obeys to the fact in many cases affiliation is done when care is needed and not with anticipation. In a regular insurance system with a premium payment this would be considered an “adverse selection” but since the aim of the PFHSD is to eliminate barriers to access it should not be regarded as a program failure.

In order to grant the permanence of the program the MCG presented a proposition to the local congress that approved the law that explicitly turns the PFHSD into a government responsibility and therefore a demandable and universal right in Mexico City in May of 2006.

A measure of the impact of the PFHSD on access to and use of health care service is the increase of service provisions during the period 2000 to 2005 that can be observed in table 1.

Table 1. Services provided by the Secretariat of Health, Mexico City, 2000–2005

<table>
<thead>
<tr>
<th>Concept</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>Percent increase 2000 to 2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultations$^{\prime}$</td>
<td>4,818</td>
<td>4,207</td>
<td>4,956</td>
<td>9,51</td>
<td>5,211</td>
<td>8,60</td>
<td>4,997,828</td>
</tr>
</tbody>
</table>
Table 1 shows that the provision of health care services by the health secretariat in Mexico City has in general increased year by year from 2000 to 2005 and a better utilization of its facilities (larger occupancy and shorter hospital stays) is also a significant feature. However it is striking that during this period the number of out patient consultations were almost unchanged or even dropped while more expensive services increased substantially; emergency care increased 35 percent, number of hospitalized persons 38 percent, births 62 percent, surgeries 81 percent, laboratory tests 23 percent and X-rays 38 percent between 2005 and 2000.

Various factors could influence the demand for services. One is the growth of the population. According to official estimates (INEGI, 2006) the population of Mexico City, i.e. the Federal District, only increase 0.3 percent during the period of analysis. Others could be better quality of services or an increase in the supply of services. Both have actually occurred as will be discussed below. Although these might be contributing factors the data on, for instance, hospital occupancy shows an unutilized capacity in 2000.

The important impact of the PFHSD as such on access is confirmed by the fact that the growth of free service events is greater than the total increase of service events for all types of services but laboratory studies. Additionally for consultations the increase in free services is 4.4 percent as compared to 0.5 percent for all consultations.

<table>
<thead>
<tr>
<th>Service Type</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency care</td>
<td>572,024</td>
<td>646,078</td>
<td>754,369</td>
<td>771,588</td>
<td>752,348</td>
<td>771,085</td>
<td>34.8</td>
<td></td>
</tr>
<tr>
<td>Hospital care</td>
<td>89,973</td>
<td>92,225</td>
<td>108,441</td>
<td>112,092</td>
<td>117,657</td>
<td>124,316</td>
<td>38.2</td>
<td></td>
</tr>
<tr>
<td>Hospital occupancy (%)</td>
<td>56.4</td>
<td>59.9</td>
<td>68.4</td>
<td>66.2</td>
<td>69.0</td>
<td>71.4</td>
<td>26.6</td>
<td></td>
</tr>
<tr>
<td>Average number of hospital days</td>
<td>4.4</td>
<td>4.2</td>
<td>4.1</td>
<td>4.0</td>
<td>4.1</td>
<td>4.0</td>
<td>-0.9</td>
<td></td>
</tr>
<tr>
<td>Surgeries</td>
<td>42,564</td>
<td>50,399</td>
<td>59,913</td>
<td>67,501</td>
<td>70,111</td>
<td>77,085</td>
<td>81.1</td>
<td></td>
</tr>
<tr>
<td>Births</td>
<td>30,922</td>
<td>35,137</td>
<td>41,539</td>
<td>44,661</td>
<td>47,295</td>
<td>50,139</td>
<td>62.1</td>
<td></td>
</tr>
<tr>
<td>X rays studies</td>
<td>404,878</td>
<td>452,462</td>
<td>469,376</td>
<td>501,133</td>
<td>522,118</td>
<td>558,499</td>
<td>37.9</td>
<td></td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>4,345,710</td>
<td>4,803,259</td>
<td>4,461,184</td>
<td>4,623,660</td>
<td>4,969,375</td>
<td>5,325,660</td>
<td>22.5</td>
<td></td>
</tr>
</tbody>
</table>

* Includes general, specialized and mental health consultations

These circumstances also become evident comparing the percentage of all service events that were free in 2002\(^{10}\) and 2005 which show the following data for hospitals: consultation 65 against 81 percent; hospital care 71 against 77 percent; x ray studies 91 against 95 percent and; laboratory tests 97 against 99. The corresponding data for health centers are: 60 against 71 percent for consultations; 56 against 67 for x ray studies and; 56 against 73 for laboratory tests. The discrepancies between the data from hospitals and those from health centers also suggest that the economical barrier were important and actually has been eliminated by the PFHSD since health centers used to charge less than hospitals.

Since the concern for “overuse” of services is one of the objections to free service provision it should be stress that consultations at hospitals have almost not increased. As far as hospital care is concerned it should be noted that 60 per cent correspond to obstetric causes\(^{11}\), almost 5 percent to neonatal care, 13 percent to serious injuries, 8 percent to acute serious infections, about 7 percent to abdominal surgery, 6 percent to chronic diseases. I.e there are clear-cut reasons for hospital care. On the other hand, the results of the survey referred below also confirm that the criteria for hospital care are quite strict: 17 per cent informed that they had asked to be hospitalized but only 60 per cent was actually interned.

We do not have a direct measurement of the beneficiaries’ perception of increased “life security” as a result of the introduction of PFHSD. However in a survey on its benefits among families enrolled in the program 91 percent considered that they can visit a doctor when needed; 86 percent that they are healthier and; 83 percent that they feel protected (Laurell, Zepeda and Mussot, 2005, p.230-231).

In this survey 70 percent also have the perception that the program has allowed them to satisfy other necessities. In fact a very conservative estimate\(^{12}\) of the saving of families due to the PFHSD from 2002 through 2005 is about 271 millions US dollars. The impact is not the same for all families but depends on what

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\(^{10}\) First complete year of the implementation of the PFHSD.

\(^{11}\) Given the risk for acute complications that need qualified care almost 100 per cent of births are attended at hospitals in Mexico City as well as abortions.

\(^{12}\) This estimate was calculated using the subsidized cost of services and the cost of drugs to the secretariat of health which is far below retail market prices.
services were needed. However it should be kept in mind that the so-called “catastrophic costs” calculated as a percentage of family income are quite small in absolute terms for poor and very poor families.

Enlargement and institutional strengthening of health care services

The PFHSD would not have a tangible importance unless the health care facilities of the MCG can effectively supply the services required by the affiliated families as well as by the rest of the population, for instance patients from the metropolitan areas outside the Federal District\textsuperscript{13}. The MCG’s health care units were quite deteriorated in 2000. Additionally they had a geographical location and a service focus that corresponded to the Mexico City of the sixties and seventies. There was thus an important mismatch between health needs and service delivery that particularly affected the poorest areas at the periphery of the city. Two undertakings were then urgently needed: the integral rehabilitation and reorientation of existing health centers and hospitals and, the construction of new ones according to a strategic plan based on the criteria of reducing inequity in access and of satisfying specific health needs. After equity is considered efficacy and efficiency are brought in, in order to provide the best and most appropriate treatment at the lowest possible cost to address existing needs and demands.

Twenty-five hospitals and most health centers have been rehabilitated and provided with the necessary equipment since 2001 when a permanent preventive maintenance program also was established. Two new public hospitals\textsuperscript{14} have been built in underserved poor areas with a new concept (architectural and operational) that situates the patient and his/her family at the center of all activities. The existing hospitals have also increased their capacity with new beds and services. Overall the public hospital beds increased in 28 percent thanks to these actions. During the same period five new large health centers have also been built in poor regions of the city.

\textsuperscript{13} The health care facilities of the neighborly state of Mexico with about 12 millions inhabitants are very deficient and about 23 percent of all hospital care at MCG facilities corresponds to this population.

\textsuperscript{14} One with 150 beds has most of the lacking specialties and the other is a general hospital with 120 beds and a care unit for high risk pregnancies.
As in many other middle income countries the shortage of drugs and other medical supplies used to affect negatively the quality and efficacy of service delivery. This problem has many aspects that range from inadequate administrative procedures and financial restriction to plain corruption. Through a variety of sustained and complex actions the timely provision of drugs and other medical supplies is presently around 95 percent with a drop down to 75-80 percent during the first month of the year mainly due to administrative rules concerning the utilization of the annual budget. Other measures to improve the quality of services include the implementation of evidence based guidelines to ensure proper treatment and to update the therapeutic skills of nurses and physicians.

An extensive training program has also been implemented that has involved close to 90 percent of all health personnel, both professional and administrative. In fact continuous training is a right of workers granted by the labor legislation and the collective bargaining agreement but had not been carried out systematically and was not linked to a vision of improving care. This program has been focused on technical skills and on matters such as rights and responsibilities of patients and health professionals, human rights, organizational culture, etcetera. Particularly the themes concerning rights and responsibilities have been given with a work shop format that gives space for discussion and active participation.

The issues of rights and responsibilities are crucial since there is an extended idea among health workers and also among users that the health care given at public institutions is a “favor” to the patient. This has led to bureaucratic behaviours and a lack of adequate information to patients and the public at large which both turn into barriers to care. Since these beliefs and behaviours are deeply imbedded in the institutional culture and among the population, it is a slow process to change them, particularly because it implies the transformation of existing power relations.

In this context the PFHSD and the corresponding law have played an important role since they turn health care into a government obligation and a demandable right of citizens. There is now a growing awareness among users and personnel that this is just and should be fulfilled. Survey data from a sample of beneficiaries of the PFHSD show that 83 percent knows that health is a constitutional right, 78 percent that it is a responsibility of the government, and 87
percent considers that taxes should be used to improve health. A recent survey among the personnel shows that a large majority favours the PFHSD and actively promotes it among patients. They also agree that the right to health should be enforced. These opinions coincide with those expressed during the staff meetings to inform about the new law. These changing attitudes confirm Rothstein’s hypothesis that new institutional arrangements are important not only in and by themselves but because they create new social values or norms (Rothstein, 1994). Observed from another perspective these changes in perception speak about the possibility to diminish discrimination against the poor and a growing recognition of the equal value of all human beings.

The new service model
A new health care model with an emphasis on health education, promotion, prevention, early detection and control of chronic diseases. The model includes interventions to grant public health security of the city, including health promotion, epidemiological surveillance, emergency plans in case of disasters, as well as preventive actions based on public health teams with geographically defined responsibilities.

In addition, individual preventive care is delivered through integrated interventions according to age groups. All uninsured families that enroll in the PFHSD are assigned to a health centre that keeps their records. When they attend their health center for any reason they are offered the integrated interventions. If needed, health center staff visits their homes to do the necessary follow up. Patients with problems that require more complex care are referred from the health centers to a MCG hospital and later counter referred to the same center.

The orientation of each MCG hospital is also being redefined into nodes of a network of hospitals, rather than self-contained units. A special effort is being made to set up a coordinated system to respond to emergencies that, hopefully, will include all health institutions, public and private, in Mexico City.

The main innovations have been to go from vertical programmes to integrated promotion and prevention; to introduce a new conception of participation; to promote to strengthen epidemiological surveillance, emergency plans and health
centers as the point of entry to hospital care and; to organize previously independent hospitals and health centers in a service health care network.

**Special actions against discrimination**

Two areas were the MC health secretariat is making efforts to fight specific forms of discrimination are sexual and reproductive health for women and HIV/AIDS that affects primarily the gay population (80 percent of all cases). Secure abortion and violence against women have received special attention, apart from strengthening regular programs such as contraception (including emergency contraception), pap-smears and detection of breast cancer.

A new legislation on abortion was passed in late 2000 and despite the fact that it was not very advanced, the political Right and its party – Partido de Acción Nacional – presented immediately a constitutional controversy. They lost their case in the Supreme Court but continued a very aggressive campaigning against implementation. The Secretariat in alliance with women’s organizations set out to grant professional, secure and confidential abortions at Mexico City’s hospitals. To this effect procedures were elaborated between the secretariat staff, women’s organizations and progressive lawyers that were subsequently made compulsory for the whole health care system. Simultaneously a training program for health personnel was applied by a NGO (IPAS) with the purpose to inform and increase sensitivity about abortion. Several specialized groups were formed and periodical evaluation meetings were done to detect problems and elaborate further actions to be taken. This program has had satisfactory results and despite a very strong initial pressure by right activists has acquired legitimacy among health workers and the population at large.

Violence against women is embedded in Mexican “macho” culture and is very common in all social groups. The Mexico City Government accordingly elaborated a transversal program with the participation of almost all of its secretariats and a number of civil society organizations. Within this network the secretariat of health has taken up various tasks. It set up a committee with the participation of all public health institutions with a common plan for action focusing on health issues. Among these actions an extensive training program was
launched for the detection of victims both in health centers and at hospitals; a special registration system was put in place; a wide-ranging campaign against violence was implemented at all health facilities; preventive and curative therapy is offered and; in case of need victims are channeled to get legal support or to women’s shelters. In an apparent paradox this program has increased the report of generic violence in Mexico City which is a good sigh because it speaks about a raising awareness and disapproval of this kind of violence.

The new MCG very rapidly put into place an integrated HIV/AIDS program in a cultural context of deep rooted discrimination against gays and lesbians. This program has also rested heavily on the interaction between civil society organizations, users’ organizations and health secretariat staff. Two major actions were taken simultaneously in 2001: the establishment of special HIV/AIDS center at health center where free and confidential consultation is available and free drugs for all patients that do not belong to any social security institute. These actions have been complemented with free voluntary testing for all pregnant mothers, special campaigns among youth, at prisons, work shops about safe sex, groups of mutual support among persons living with HIV, etceteras. The program has been so successful that it now is the paradigm in all Mexico and other countries.

**Popular participation and social control**

Popular participation has been invoked for a long time in public health in Mexico. Health Committees exist, at least formally, at most health centers but their role is mainly to assist in tasks such as the cleaning and maintenance of those centers. Generally they do not have a say on what to do and how to do it. The MGC has a different concept of popular participation and social control which is that there is a reciprocal relationship of rights and obligations between the government and the population. The government is obliged to grant the right to health protection, and to promote popular participation in the definition of the concrete content of this right given the available scientific and material resources, including provision of the necessary information. In return the population is obliged to contribute to efficacy in and control of the use of public resources.
As was mentioned the social policy of the MCG is mainly organized on a territorial base at 1352 city sections with an elected Council. The Assemblies are celebrated twice a year during which information is given on the advancement of the social programs and commissions are formed to deal with specific issues of interest to the neighbors. Presently 270 health commissions are active and their main task has been to do participatory action research to specify the main health problems at their city section and to formulate a local health plan in collaboration with the health committees. So far 137 of these plans have been elaborated and concrete demands have been posed to local and health authorities that concerns problems that range from clean water and sewage to concrete changes at health facilities. One of the problems faced doing participatory action research is the continuity of the groups since the process is quite time consuming and most members—women—have many other tasks.

Since 2002 the personnel at the health centers have been trained in the organization and reorientation of the local health committees to achieve a real popular participation and social control. 149 committees, that include members from the health commissions, are functioning with this orientation and have representatives at the larger Health Committees at five of the sixteen city delegations.

The specific impact of the different commissions and committees on health matters and health conditions is difficult to evaluate. However the basic organization and structure for an effective mechanism of popular participation and informed social control on health matters has been set that would also ensure transparency of government action. The perspective is to build the whole structure of health committees from below to the top but so far this has not been possible. It seem realistic to expect that the first step that could be consolidated is the social control function rather than active participation in planning.

Financial commitment and optimal use of public resources
A strong political and financial commitment to health has been critical for the MCG health strategies. The MCG health funds come from local and federal resources. In 2005 local financial resources represented 58 percent of the total health budget
which far more than other local governments dedicate to health\textsuperscript{15}. This means that close to 10 percent of Mexico City’s expenditure was dedicated that year to health, up from 8.0 per cent in 2000. The budget increase from 2000 to 2005 has been 59 percent.

This large increase was possible thanks to an austerity program that cut superfluous government spending, including a fifteen percent reduction in the salaries of high officials, a reduction of their previously large number, and the elimination of other allowances such as private medical insurance, unlimited credit cards expenditure for representation costs, etceteras. This was accompanied by a frontal attack on corruption. Through this program public resources are shifted from the government to the public in the form of social services. Furthermore it is a concrete and observable measure of progressive income redistribution. The austerity program allowed the MCG to save about 200 million US dollars in 2001 and 300 million US dollars yearly from 2002 to 2006 which were integrally dedicated to social programs.

Although an increase in the health budget was necessary it was also imperative to apply it efficiently and with transparency, i.e. to make an optimal use of the resources that the public provide to the government. This issue concerns two basic aspects. One speaks to planning and good administrative practices and the other to struggle against corruption. The planning has concerned both the strategic aspects of the Secretariat and the operational processes at all levels.

A crucial area is the chain of purchase-distribution-utilization of medical supplies because it involves the quality of service delivery and a substantial part of the health budget. It is also a critical area in terms of corruption. Each phase of this chain has been analyze and improved resulting in: a new methodology to determine needed supplies based on observed service demand at the point of the patient; changes in the purchasing procedures, including new legislation; and a computerized system that identifies in real time consumption and flaws in distribution. Some of the positive outcomes are: an improvement in timely and

\textsuperscript{15} According to official federal data in 2004 local state funds only represent 17.7 percent of the total public health budget for the uninsured population.
sufficient provision of medical supplies; better prescription practices; a decrease in misuse and waste and; some important savings in prices\textsuperscript{16}.

The new administrative procedures are in themselves a break on corruption because they increase transparency, rationality and controls. The government also introduced a citizen representative\textsuperscript{17} at all government departments where contracting is done. One of the criteria for appointing high level government officials is that they are known to be honourable and have a clean service record. They also have to declare each year their incomes and possessions; declarations that are subject to public scrutiny.

**Health impact**

The relative impact of health care services on health is a controversial issue that is discussed in another part of this Report. In the specific case of the health care services of the MCG, a part of the segmented health sector in the city, it is not possible to assign its specific contribution to the changes observed in the health conditions of the population. Additionally we do not have reliable systematic data on morbidity or even less any indicators on positive health.

The mortality by age group during the period 1997 to 2005 is exposed in table 2 and should be interpreted taking into account these limitations. In all age groups both the number of deaths and the death rates have declined with the exception of the postproductive one which shows an increase in the number of death but a 7.9 percent decline in the death rate. It is however reasonable to hypothesize that the removal of the economic barrier to care and therefore a more timely treatment as well as integrated primary care have contributed to the declining mortality rates.

What is behind this summary data is a rapid decline in infectious and nutritional diseases and the emergence of chronic diseases. By 2005 acute respiratory infections were the 18\textsuperscript{th} cause of death and diarrheas the 20\textsuperscript{th}. Unlike other big cities injury and homicide have not varied much during the last five years.

\textsuperscript{16} For instance the new purchasing procedure resulted in drug prices that were 23 percent lower in 2005 than in 2004.

\textsuperscript{17} These representatives have free access to all acquisition events (purchasing and building contracting), government contracts and can object procedures and follow up processes. If irregularities are found they denounce them to the control authority ("Contraloría") that investigates and can take legal action.
and show a slow tendency to decline. Also it is observable that some of the ailments where complex care makes a difference such as AIDS, premature neonatal survival, congenital malformations, pneumonia, gastric ulcer, among others, have steadily declined.

### Table 2 Evolution of the number of deaths and death rates, Mexico City, 1997-2005

<table>
<thead>
<tr>
<th>Year</th>
<th>General Number</th>
<th>Rate 1/</th>
<th>Infant Number</th>
<th>Rate 1/</th>
<th>Preschool Number</th>
<th>Rate 1/</th>
<th>School Number</th>
<th>Rate 1/</th>
<th>Productive Number</th>
<th>Rate 1/</th>
<th>Postproductive Number</th>
<th>Rate 1/</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997</td>
<td>46,884</td>
<td>5.4</td>
<td>3,848</td>
<td>24.0</td>
<td>425</td>
<td>0.8</td>
<td>459</td>
<td>0.28</td>
<td>17,571</td>
<td>3.2</td>
<td>24,560</td>
<td>52.2</td>
</tr>
<tr>
<td>1998</td>
<td>46,773</td>
<td>5.4</td>
<td>3,699</td>
<td>23.6</td>
<td>445</td>
<td>0.7</td>
<td>440</td>
<td>0.27</td>
<td>17,336</td>
<td>3.0</td>
<td>24,840</td>
<td>49.5</td>
</tr>
<tr>
<td>1999</td>
<td>46,601</td>
<td>5.3</td>
<td>3,323</td>
<td>21.6</td>
<td>381</td>
<td>0.6</td>
<td>376</td>
<td>0.23</td>
<td>16,711</td>
<td>2.8</td>
<td>25,793</td>
<td>49.9</td>
</tr>
<tr>
<td>2000</td>
<td>46,029</td>
<td>5.2</td>
<td>3,127</td>
<td>21.6</td>
<td>365</td>
<td>0.6</td>
<td>402</td>
<td>0.26</td>
<td>16,535</td>
<td>2.8</td>
<td>25,567</td>
<td>47.8</td>
</tr>
<tr>
<td>2001</td>
<td>46,627</td>
<td>5.3</td>
<td>2,894</td>
<td>20.0</td>
<td>384</td>
<td>0.7</td>
<td>396</td>
<td>0.26</td>
<td>17,003</td>
<td>2.8</td>
<td>25,931</td>
<td>47.3</td>
</tr>
<tr>
<td>2002</td>
<td>46,984</td>
<td>5.3</td>
<td>2,858</td>
<td>19.9</td>
<td>368</td>
<td>0.6</td>
<td>378</td>
<td>0.25</td>
<td>16,875</td>
<td>2.8</td>
<td>26,490</td>
<td>47.0</td>
</tr>
<tr>
<td>2003</td>
<td>48,586</td>
<td>5.5</td>
<td>2,807</td>
<td>19.7</td>
<td>340</td>
<td>0.6</td>
<td>408</td>
<td>0.27</td>
<td>17,289</td>
<td>2.9</td>
<td>27,716</td>
<td>48.0</td>
</tr>
<tr>
<td>2004</td>
<td>48,950</td>
<td>5.6</td>
<td>2,676</td>
<td>19.0</td>
<td>349</td>
<td>0.6</td>
<td>352</td>
<td>0.24</td>
<td>17,032</td>
<td>2.8</td>
<td>28,541</td>
<td>48.1</td>
</tr>
<tr>
<td>2005</td>
<td>49,882</td>
<td>5.7</td>
<td>2,592</td>
<td>18.7</td>
<td>322</td>
<td>0.6</td>
<td>398</td>
<td>0.28</td>
<td>17,283</td>
<td>2.8</td>
<td>29,257</td>
<td>48.1</td>
</tr>
<tr>
<td>Dif. 2005-1997</td>
<td>2,998</td>
<td>0.3</td>
<td>-1,256</td>
<td>-22.3%</td>
<td>-103</td>
<td>-25.5%</td>
<td>-61</td>
<td>-2.4%</td>
<td>-288</td>
<td>11.3%</td>
<td>4,697</td>
<td>-7.9%</td>
</tr>
</tbody>
</table>


1/ rate per 1,000 life births  
2/ rate per 1,000 persons

Among the chronic diseases diabetes is particularly outstanding with a mortality increase of 64 percent between 1990 and 2004 and 22 percent during the last five years. Cardiovascular diseases, frequently associated to diabetes, showed an increase of 14 percent and cancer 9 percent during the same period. In the analysis of these data it should be taken into consideration that chronic diseases have a much longer and variable “latency” than acute infectious disease.

Some specific cases of the direct health impact of the MCG policy are available. One is the impact of the AIDS program on mortality and on early detection and treatment. In 2001 practically all new patients that were integrated to the program where in immediate need of drugs (and got them). By 2006 this proportion had declined to about 80 percent and patients with treatment show a very satisfactory normalization of CD4 and viral charge. AIDS mortality in Mexico City has declined steadily from 6.9 per 100,000 in 2001 to 5.8 in 2005 which represents a 16 percent decrease.

Maternal mortality has also declined at the MCG hospitals close to 25 percent as a result of special actions taken with a combination of training, a specialized
mobile group and the creation of two new units of neonatal and maternal intensive care. The improvement would have been more important if only women from the city had been attended since the most serious cases are women from other states that lack adequate services and arrive in very critical conditions.

What could be safely stated is that the present disease pattern in Mexico City can not be changed unless universal coverage and integrated health care is available. Although the epidemiological transition with the emergency of a new disease pattern has to do with a variety of social determinants of health, it is also clear that innovative epidemiological surveillance and integrated health care for everybody, with a continuum of health education, promotion, prevention, early detection and control, are fundamental to modify the prevalence and outcome of these diseases. Furthermore in many cases complex care is needed and it is unacceptable to exclude the poor population from access to these services that means a better quality of life or even make the difference between life and death.

Conclusions and final considerations
Mexico City government’s health policy offers some experiences that could be lessons to other policy makers. It shows that a local government can grant the universal right to health even with a segmented health care system and in the context of a distinct national policy. The preconditions that made it possible were the previous decentralization of health services to the federated states and the capacity to mobilize sufficient financial and technical resources to instrument an autonomous and effective policy. This in turn was the result of the political decision to give the highest priority to the resolution of social problems in general and to health problems in particular. Given its relation to the needs of the people this policy has gained a growing popular support since citizens have obtained real benefits in their daily life. This is confirmed by the election results in Mexico City in 2006 where its former governor took 58 percent of the vote as a presidential candidate in an election between five candidates\textsuperscript{18}.

The redirection of public resources from the expenditure on privileges of high government officials towards social programs and the sustained fight against

\textsuperscript{18} The next two parties taken together received 34\% of the vote
corruption have created a new credibility in the government and increased popular support. These actions have also shown to be an abundant source of money and a force to stimulate an ethical sense of service among government officials as well as a tangible example of progressive income redistribution.

The instrument used to grant universal access to needed health care services, the Program of Free Health Services and Drugs (PFHSD), is widely accepted (with about 95 percent of eligible families enrolled) and has eliminated economic barriers to access as demonstrated by a 30 percent increase in service provision of expensive care. The design of the program promotes equity since it postulates equal access to existing services given the same necessity instead of a predetermined package of services, i.e. those enrolled in the programme do receive all available services they might need and not just a cost-effective package that also tend to fracture a continuous process of care.

Survey data among the affiliated population suggest that the program has additionally increased the feeling of “life security” since 83 percent reported to “feel protected” by the PFHSD which might have an impact not only on well-being but also on health. It also favours the poor population despite the absence of means testing; survey data on the enrolled population show that it has lower income, less education and more frequently lives in the poor areas of the city than the population at large (Laurell et al. 2005, p. 227-228). This confirms universalism as the best option to fight poverty (Mkandawire, 2005). Furthermore free health care and drugs have allowed considerable savings –271 million US dollars— which could be spent by families for the satisfaction of other basic needs. However remaining cultural obstacles to access to health care are still to be removed.

The PFHSD became viable due to a sustained effort to strengthen and expand existing health care facilities and to a new model of health care based on health education, promotion, prevention, early detection and control of diseases. The thrust to dignify services and improve their quality has involved a variety of planning, administrative and educational actions which have also served to fight corruption. The new forms of popular participation and social control have also contributed to this end. More efforts are however needed to change institutional
practices and culture so as to grant that the general interest, i.e. the one of the public, prevails over the particular interests of different actors.

Although advances have been achieved in the institutional culture it is still necessary to overcome discrimination against the poor, women, ethnical and sexual minorities that prevails in a society deeply marked by inequality. A different aspect of cultural obstacles to health care is the cultural exclusion of the same groups, with the possible exception of women, because they do not know that they have rights and entitlements and therefore do not claim them. The tolerance for blatant inequality is the most fundamental problem of Mexico (that certainly has increase during the last two decades) and has to be fought in all terrains.

It is also crucial to institutionalize the achieved changes and transparency to protect them during the transition from one administration to another. The new legislation, that obliges the MCG to provide free health care services and bestows on citizens the demandable right to receive them, strengthens the institutionalization of change. Furthermore the existence of the program and the law represent a new institutional arrangement which tend to create new social values. In fact, users and health personnel increasingly consider the universal right to health protection as legitimate and, in accordance, a government responsibility.

The evaluation of the health impact of the MGC health policy cannot be straight forward since there are many intervening elements. However mortality rates by age group have dropped systematically during the last eight years. It should be stressed that during this period that corresponds to the governments\(^{19}\) of a left party—the PRD—a progressive social policy has been implemented apart from the health policy.

The analysis of the MCG health policy suggests that it has avoided or reversed some of the main problems of the conventional health reforms in Latin America (International Society for Equity in Health, 2006) that are similar to the dominant national health policy in Mexico. Unlike the national policy access to services is not conditioned to the payment of an individual insurance premium; there is not a gradual implementation and therefore no new segment of the health care system has emerged; coverage is not limited to a service package but people

\(^{19}\) The first from 1998 to 2000 and the second from 2001 to 2006.
can use all available services; there is not just an increase in financial resources but also a serious effort to strengthen and broaden public services and; new values of equity and justice are materializing.
References


Decreto por el que se reforma y adiciona la Ley General de Salud. Diario Oficial de la Federación. 15 of May, 2003.