Meeting on improving health system efficiency and strengthening Primary Health Care

Fund for Protection from Catastrophic Expenses: The experience of Mexico

Francisco Garrido Latorre MD, PhD
Overview

• Background of the Mexican Health System
• Health reform objectives
• The System for Social Protection in Health
• Seguro Popular (The Popular Health Insurance)
• Fund for Protection from Catastrophic Expenses

General characteristics

Results

Payment of providers

Inefficiencies

• Defficiencies and future challenges
### Background: Mexican Health System

<table>
<thead>
<tr>
<th>Sectors</th>
<th>Public</th>
<th>Private</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ministry of Health</strong></td>
<td><strong>Social Security</strong></td>
<td><strong>Employers and individuals</strong></td>
</tr>
<tr>
<td>Funds</td>
<td>Federal and state governments + individuals</td>
<td>F. government + employers + employees</td>
</tr>
<tr>
<td>Purchasers</td>
<td>Local State Regimes for Social Protection in Health (REPSS)</td>
<td>Social security institutions (IMSS, ISSSTE, PEMEX, SEMAR and SEDENA)</td>
</tr>
<tr>
<td>Providers</td>
<td>Federal and state clinics and hospitals with their own health personnel</td>
<td>Social security clinics, hospitals and their own health personnel</td>
</tr>
<tr>
<td>Beneficiaries</td>
<td>Self-employees, unemployed, others</td>
<td>Workers of the formal sector of the economy and their dependants</td>
</tr>
</tbody>
</table>
Background: prior to the Health reform

<table>
<thead>
<tr>
<th>Indicators</th>
<th>2002</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health expenditure as a share of GDP (%)</td>
<td>5.6</td>
</tr>
<tr>
<td>Private share in health expenditure (%)</td>
<td>53.3</td>
</tr>
<tr>
<td>Public expenditure on insured/uninsured population ratio.</td>
<td>1.9</td>
</tr>
<tr>
<td>Households with catastrophic expenditures (%)</td>
<td>2.7</td>
</tr>
<tr>
<td>Ratio of federal per-head expenditure on health in the state with the highest figure to that in the lowest.</td>
<td>6.1 to 1</td>
</tr>
<tr>
<td>Uninsured population (million)</td>
<td>50.0</td>
</tr>
</tbody>
</table>
Health Reform 2003: objectives

- Ensuring universal coverage of health services
- Injecting new resources into the public system, and re-balancing the financial transfer from the federal government to the states.
- Improving financial protection for those without social security.
- Facilitating the portability of insurance across states and insurance schemes, allowing the functional integration of provider networks.
- Reforming the organisation and functioning of the state health systems to ensure better management and establish incentives to promote equality, technical efficiency, and responsiveness.
The Health reform set up the System for Social Protection in Health, whose medical component is the Popular Health Insurance (*Seguro Popular*).
# Dimensions of Social Protection in Health

<table>
<thead>
<tr>
<th>Dimensions</th>
<th>Main actions</th>
<th>Policy instruments</th>
</tr>
</thead>
</table>
| **Protection against health risks** | • Epidemiological surveillance  
• Health promotion  
• Disease prevention  
• Risk mitigation | • New public health agency (COFEPRIS)  
• Health card scheme with gender and life-course perspective  
• *Fund for community health services* |
| **Patient protection**       | • Quality of care assurance  
• Safety  
• Effectiveness  
• Responsiveness | • National Crusade for Health Quality |
| **Financial protection**     | • Comprehensive health insurance | Seguro Popular  
• Fund for essential health services (CAUSES)  
• Fund for protection against catastrophic health expenditures |

Seguro Popular: Sources of Financing

- **Social Quota** (3.92% annual minimum wage) USD 79.0
  - **Federal solidarity contribution** (1.5 times the Social Quota) USD 118.5
  - **State solidarity contribution** (0.5 of Social Quota) USD 39.5
  - **Individuals** Premiums: According to ability to Pay

**Source:** own elaboration with CNPSS information (Informe de Resultados 2012)

1 USD = 12 MXP
Seguro Popular: origin, destiny and uses of financial resources

Origin

- Federal Government
- State Governments
- Individuals

Destiny

- CAUSES package\(^1\)
  - State Health Services (89%)
- FPGC\(^2\)
  - (8%)
- Budgetary Provision Fund (3%)
- State Health Services

Uses

- Primary and Secondary Care
- Tertiary Care
- Infrastructure equipment, and interstate services
- Pharmaceuticals

Source: CNPSS, Informe de Resultados 2012

\(^1\) CAUSES: Universal Health Essential Services Catalogue
\(^2\) FPGC: Fund for Protection from Catastrophic Expenses
Fund for Protection from Catastrophic Expenses (FPCE)

Basic characteristics

- **Fund**: 8 percent of the PHI resources
- **Risk pooling**: at the national level
- **Provision of services**: public and private with tertiary level units or with specialised services at the second level. Compulsory accreditation for FPCE providers is needed.
- **Coverage**: 59 interventions
- **Payment**: by medical event
- **Beneficiaries**: people not covered by social security
From 2004 to 2013 the FPCE has financed the medical treatment of 849,024 cases.

Seven interventions comprise nearly 98 percent of the total cases: ambulatory treatment of HIV/AIDS, cataracts, neonatal intensive care, breast cancer, cervical cancer, surgical congenital disorders and child cancer, respectively.

The most expensive interventions have been: Lisosomal Storage Diseases, bone marrow transplant, Non-Hodking linfoma, breast cancer, and child cancer.
Types of providers

<table>
<thead>
<tr>
<th>Type of providers</th>
<th>Number of providers</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Second level</td>
<td>Third level</td>
</tr>
<tr>
<td>State hospitals</td>
<td>117</td>
<td>29</td>
</tr>
<tr>
<td>Autonomous hospitals</td>
<td>8</td>
<td>24</td>
</tr>
<tr>
<td>Private hospitals</td>
<td>8</td>
<td>20</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>133</strong></td>
<td><strong>73</strong></td>
</tr>
</tbody>
</table>

Source: own elaboration with data from CNPSS

- Public autonomous hospitals and private clinics have shown better performance and health outcomes than state health services.
In Autonomous hospitals:
The personnel receives
• Non-financial incentives: support to professional development and intrinsic rewards (teamwork strengthening).
• Increased number of patients promotes the development of research.

The hospital receives
• More equipment and consumables

In State hospitals
• Occasional improvement in equipment and consumables
Payment of providers

- Direct payments *per medical event* made by federal government to autonomous (OPD) and private hospitals.

- Indirect payments *per medical event* made by federal government through State Health Services (MoH) to hospitals.
Inefficiencies

Evaluation and research studies on FPCE have shown the following inefficiencies:

- Failures in the early detection of cases in the Primary Health Care (for example, breast and cervical cancers).
- Lack of supply of drugs and other consumables included in the package (resulting in out-of-pocket expenditures for the patients); shortage of medical specialists; insufficient follow-up of the patient due to nonexistent resources for the attention after hospital discharge.
- Late reimbursement from the Federal government to providers puts at risk the health unit finances.
- Lack of geographic coverage for some interventions (for example: bone marrow, renal and corneal transplant, LSD, Hemophilia and Non-Hodking linfoma).

Instituto Nacional de Salud Pública/CISS, 2013. Evaluación externa del FPGC
Reform outcomes

From 2004 to 2012 there have been improvements in the availability, distribution, and allocation of financial resources\textsuperscript{1-2}.

- Total health expenditure grew 1.3 percentage points (2000-2010)
- Public spending as a percentage of total health expenditure has grown slowly in the period (5%)
- Gaps between public expenditure on insured and uninsured population declined 57%
- The MoH budget increased 142% in real terms between 2000-2010
- The difference between the highest and the lowest allocation of federal resources per person among states declined 50%.

Financial protection

- Catastrophic expenditures in Seguro Popular households declined 27%
- Out-of-pocket spending by Seguro Popular enrollees has dropped 30%

Sources: \textsuperscript{1}INSP, 2012. Evaluación externa del Sistema de Protección Social en Salud. \textsuperscript{2}Knaul F., González-Pier E., Gómez DO, et al. The quest for universal health coverage: achieving social protection in health

http://dx.doi.org/10.1016/s0140-6736(12)61068-x
Reform outcomes

**Seguro popular enrollment**\(^1\)
- 57.3 million
- 99.7% in the non-contributory regimen
- 33.6% of enrollees from the rural areas

**Provision of health services**
- The package of essential services (CAUSES) grew from 91 interventions in 2004 to 285 in 2012, covering treatment for 95% of causes in ambulatory units and general hospitals.
- Interventions covered by FPCE grew from 4 in 2004 to 59 in 2013.

**Use of health services**\(^2\)
- From 2006 to 2012, the MoH hospital discharges increased 42%
- The proportion of births at MoH facilities increased from 32% to 48%, while in private entities declined from 25% to 19%, and in social security hospitals from 35% to 26%

Sources: \(^1\)CNPSS, Informe de Resultados, enero-junio 2014. \(^2\)INSP, 2012, Evaluación externa del Sistema de Protección Social en Salud
Defficiencies and challenges

- The health system remains fragmented and vertically integrated.
- Scarce or non-existent efforts by state MoH to progress toward the separation of financing and provision.
- Lack of transparency and accountability regarding the use of public resources.
- To support and improve the managerial abilities at state and local level organisations.
- To expand, train and retain health workforce
- To strengthen quality of care policy focusing on accrediting health units, health care processes and health outcomes.
- Back to basics: to change the current Hospital-centred Health Care model to Primary Health Care.