Lessons of health finance dialogue from Mexico’s reform experience

Implementation of the Collaborative Agenda on Fiscal Space, Public Financial Management (PFM) and Health Financing

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Basic health sector data

- Population 121 m
- 79% urban <5: 9.1%; >65: 6.2%
- Fertility rate: 2.2
- Life expectancy: 77 (79 women; 74 men)
- U5MR: 13 per 1,000 live births
- MMR: 38 per 100k live births
- Mortality: CVD, diabetes (growing problem with diabetes)
- GDP / capita: 10,325.6 USD
- Health sector spending: 6.3% of GDP
- 677 USD per capita spending
- 51.8/48.2 Public – Private (OOP) financing
- Fragmented health system: 50% social insurance schemes / 50% Seguro Popular

Sources: Data 2014/2015, World Bank Indicators, MOH data and National Population Council data.
## Country approach to UHC

### Before 2004

- Various initiatives, aimed at expanding coverage managed to cover specific population groups, were promoted.
- None of these led to UHC
- Large gaps in financing/access/health conditions across population groups

### Important financial imbalances prevailed

1. Per capita allocations of federal monies between social insurance and the rest of population (2.5 to 1)
2. Per capita allocation of federal monies across states (4.3 to 1)
3. Per capita allocation of complementary state-level funding (115 to 1)
4. Family based contributions based on socioeconomic level
5. Underinvestment in equipment and infrastructure.
Country approach to UHC

Seguro Popular financial principles:

1) Democratic – Money following patients: capitation and per case reimbursements.

2) Fair - Legally mandated co-financing per capita rules for federal government, states, families.

3) Accountable to patients - Two explicit benefit packages

4) Efficient - Use of “new” health financing tools: risk adjusted capitated payments, quality accreditation to providers, performance evaluation, health technology assessments + others

5) Sustainable - Transition from uncontrolled agency specific budgets to legally mandated allocations based on enrolled population with a 7 year transition phase.
12 years after Seguro Popular – the Good

• UHC has been achieved in its **first stage**: universal enrollment. All the population have right to access to one of several publicly financed health insurance schemes (social security, *Seguro Popular*, etc.)

• Significant progress has been made in the **second** (regular access to a comprehensive package) and **third** (preventing financial shocks by reducing OOP) stages.

• **Public funding** for the population who did not have access to social security **increased** significantly (114% in real terms between 2004 and 2015).

• The **gap** in per capita public financing of different insurance schemes has been **reduced**: from 2.4:1 to 1.5:1 (between 2004 and 2014).

• **Better stewardship** was developed – instruments have been created to monitor outputs and performance evaluation (health gains and financial protection) and supply strengthening provisions (hospital management, lung run infrastructure planning, technology assessment agency).
12 years after Seguro Popular - the Bad

- Not everybody has “effective access” and there is large heterogeneity in the interventions covered across publicly-funded insurance schemes.

- **Quality of care** remains a pending agenda (more monies deliver more clinical activity with uncertain outcomes). Accreditation of providers (both public and private) has been slow.

- **Supply-side response** was uneven across inputs (response capacity of human resources for health was overestimated). Bottlenecks to implement breast cancer screening.

- Introduction of annual service agreements with expenditure limits by budgetary items (40% personnel, 30% medicines and materials, etc) and reference prices for drugs

- **Decentralization** of service delivery created large performance gaps in performance (especially with managerial capacities at the state level).

- Slow progress with **purchaser-provider split** at state level

- **Community-based public health interventions** became a neglected financial agenda
Building a partnership with the MoF

Stress the legal/ethical imperatives ...

- The constitutional/legal mandate for “the right to health”
- Access to health as a human right
- Fair health financing as part of fiscal equity principles

... and its compatibility with sound financial principles

- Value for money
- Sustainability (effective cost containment strategies)
- Efficiency (counter mismanagement, corruption, wastage)

Exercise team work to build trust when:

- Approaching subnational governments
- Avoid budgetary gaming (e.g. family vs individual capitated payments).
- Promoting support of population groups for fiscal measures (VAT example)
- Avoiding pressures along party lines (budget appropriations).
How to frame the new MOH/MOF dialogue

Health Systems

Health

Economic Performance

Labor-market-based social security vs citizenship based social protection of health

Economic value of averted premature mortality and disability