

*Yale Center for the Study of Globalization*

# UHC Charter Expert Papers

TOPIC OF FOCUS

**UHC can be reached in Mexico.**

Santiago Levy

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### Background

Mexico is a good example of the shortcomings associated with a segmented health system but also of the feasibility of UHC. The government began to deliver health care services in 1943, as part of an ambitious effort to provide Mexican workers with social insurance. The scheme adopted followed the Bismarckian model: workers and firms would contribute with a payroll tax earmarked to fund workers' pensions and health, day care and other services for them and their families. In parallel, the Mexican Institute of Social Security (IMSS for its acronym in Spanish) was created as a vertically integrated organization that would both collect and administer the contributions, and provide services.

When IMSS began operations, the expectation was that the number of workers covered by it would increase gradually to eventually include all, as a result of urbanization, industrialization and economic growth; expanding formal employment –that covered by IMSS-- was the route to the stated aim of UHC. While this happened, the Ministry of Health would provide those not yet covered by IMSS –labelled informal workers-- with basic primary care funded from general government revenues. Thus, a dual system of public health provision was born, with asymmetries in terms of the scope and quality of care (higher for formal than informal workers); sources of funding (ear-marked payroll taxes versus general tax revenues); and administrative arrangements (a specialized institute with its own facilities and labor union for formal workers, and separate facilities for informal workers operated by another labor union). In parallel, one system was expected to be permanent and the other transitory.

As the 'lost decade' of the 1980's ended, it became clear that the share of the labor force formally employed was stagnating. Faced with a large and growing number of people excluded from IMSS, and more complex health needs, starting in the 1990s successive governments increased resources and efforts to improve the scope and quality of health services for informal workers and their families beyond basic primary care. This was done through various programs that overtime changed in name, degree of involvement of subnational governments, and budgetary arrangements. In 2003 these efforts were partly systematized under a program known as Seguro Popular; more recently, in 2019, this program was replaced by a new Institute of Health for Welfare (INSABI, for its acronym in Spanish), with new budgeting and administrative arrangements between the Federal and state health ministries. But regardless of how these programs were labelled and organized, the underlying feature was the provision of free and gradually improving health services for informal workers conditional upon informal employment; in combination with IMSS-provided services for formal workers funded from a payroll tax. *De facto*, what was expected to be a transitory arrangement became a permanent one.

Over the last 25 years the gap in scope and quality of health services offered to formal and informal workers families has narrowed. Today, health spending per capita is only between 10 to 15% higher in IMSS (covering around 45% of privately employed workers) than in INSABI (covering the other 55%). That said, however, there are large regional variations within IMSS and INSABI in the number of primary clinics, hospitals, nurses and doctors; implying large differences in the quality of care within and across institutions. Thus, although everybody in Mexico is in principle entitled to publicly provided health services, not everybody is entitled to the same scope and quality of services; and in practice for some groups the gaps are wider than for others. Indeed, it is estimated that in 2016, out of a population of 120 million people, around 19 million had no access at all. Thus, more than 75 years after the initial efforts to achieve UHC, the country is still far from providing all of its citizens with the same services, funded from the same revenues.

### **Low quality of services, inequities and large economic distortions**

Contrary to what is often assumed, workers in Mexico cannot be separated into those that are always formally employed, and those that are always informally employed. Rather, the labor market is characterized by substantial fluidity, with the same workers sometimes having a formal job and sometimes an informal one. Panel data from Mexico's employment survey indicates that around 20% of workers transit from formal to informal status in one year (or vice versa). Longer term data from the registries of the pension system confirms these movements.

Large transits imply that the same workers are sometimes enrolled with IMSS and sometimes with INSABI, an undesirable feature from the point of view of health provision, as treatments are interrupted or have different scope. To give an example, a study shows that the clinical efficacy of IMSS treatments for diabetes mellitus, perhaps the largest public health problem in Mexico, falls by 19% as workers initially treated by IMSS change labor status and move on to be treated by INSABI.

Transits between formal and informal employment imply that, for all practical purposes, Mexico has two separate public institutions, with separate facilities, funding mechanisms, administrative apparatus and labor unions, to provide health services to essentially the same population (plus a separate institution for public-sector workers, and yet another one for workers of the state owned oil enterprise!). All this creates substantial inefficiencies and helps to understand why of all countries in the OECD, Mexico is the one that devotes the largest share of expenditures in health to administrative costs: 8.9% versus an average of 2.6% for other countries in that organization.

Aside from inefficient, the system is also inequitable. While very few individuals spend all of their working lives formally or informally employed, data shows that higher income individuals spend relatively more time in formality than lower income ones. Thus, higher income individuals are likely to be treated more often by IMSS, and lower income ones by INSABI, an undesirable feature from the perspective of equity; those who need public health care the most get the least.

Low formal employment, insufficient resources for health, inefficiencies and duplication of functions across four providers, and deficiencies in supervision and corruption, all combine for a public health system that delivers mediocre benefits to Mexico's population. Out-of-pocket expenditures are 41% of all health expenditures, versus an average of 20% in other OECD countries, and 28.6% in other countries of Latin America. Indicators of health outcomes are also disappointing. For instance, Mexico's rate of one-year child mortality is 12.5 for every 1,000 born, almost three and a half times the average of OECD countries, at 3.6.

In parallel, the combination of payroll taxes and general government revenues used to fund IMSS and INSABI, respectively, implies a tax on formal employment of around 14% of the average formal wage, and a subsidy to informal employment estimated at 17% of the average informal wage; exactly the opposite of what is needed to stimulate formal employment. Lastly, the segmentation of health funding and provision imposes a sharp trade-off on the country: efforts to close the gap in spending and quality between IMSS and INSABI, while clearly desirable from the point of view of health and equity, would further increase the subsidy to informal employment, widening the distortions that contribute to the persistence of Mexico's large informal sector, and the factors that depress productivity and growth. Low income informal workers may get better health services, at the expense of better jobs; and health equity might increase, at the expense of faster growth.

### **Mexico can transit towards UHC**

Four obstacles need to be overcome to change the present system into one that is more equitable and efficient and delivers better quality services to all, while by-passing the costly distortions associated with the current combination of payroll and other taxes used to fund services:

- IMSS facilities and personnel dedicated to providing health services need to be separated from the rest of IMSS, creating a new institution exclusively dedicated to providing health services. This new institution, tentatively labelled IMSS-Health, would be placed under the control of the Ministry of Health;
- IMSS-Health should be funded at its current level of per capita expenditures with general tax revenues, eliminating the share of payroll taxes currently collected by IMSS for health services (while leaving the remaining share for pensions and other benefits);
- per capita funding for INSABI needs to be increased to the level of IMSS-Health, so that both providers have the same resources per capita to in principle provide services of the same scope and quality;
- the Ministry of Health should be given the control of the budget for IMSS-Health and INSABI in a single fund that pools all resources, and the mandate to eliminate duplications of administrative systems, optimize the use of facilities and unify medical protocols, accompanied by more effective mechanisms for transparency and accountability.

Critically, because all public health provision would be funded from general tax revenues, and the quality and scope of services would be the same for all, the distinction between formal and informal employment would be immaterial from the point of view of health. In effect, access to health services would be completely independent of workers status in the labor market. Workers and their families could be indistinctly treated in IMSS-Health or INSABI facilities, by nurses or doctors of either institution. Indeed, ignoring public sector workers, Mexico would have UHC. Of course, aging and the epidemiological transition would impose increasing resource needs, but Mexico would have an appropriate architecture to channel more resources to its public health system, without wasting them in administration or increasing costly economic distortions.

Can these obstacles be overcome? The first one requires mostly political will, especially if the labor contract of workers under IMSS-Health is the same. IMSS would cease to be a provider of health services, but the nurses, doctors and related personnel would keep all their labor rights and union contract;

The second and third require more fiscal revenues, as the costs of both eliminating payroll taxes to fund IMSS-Health, and equalizing INSABI per capita expenditures to those of IMSS-Health, is estimated at 1.25% of GDP. In the case of Mexico, however, a fiscal reform to increase revenues by that amount for UHC would be amply justified. On one hand, payroll taxes would decrease, implying that the net increase in the tax burden would be smaller. On the other, Mexico's tax burden is among the lowest in the OECD, and there are many exemptions to income and consumption taxes that could be reduced or eliminated (some of which could have the added virtue of also contributing to reduce informality, in addition to the reduction in payroll taxes).

The fourth obstacle, finally, requires mostly perseverance and administrative capital, as the process of unifying two parallel systems of health delivery is undertaken. The institutional, budgetary and fiscal obstacles pale in comparison with the complexities of revamping the organization of currently existing health services. Time is needed to gradually reduce administrative personnel; merge procurement systems, preventive and curative protocols and electronic medical records; strengthen facilities in remote rural areas and urban slums that are currently underserved by IMSS and INSABI; and develop new mechanisms to increase transparency and accountability, ensuring that more money translates into more health, not more waste or corruption.

All in all, the legal, fiscal and organizational obstacles to transit towards UHC in Mexico can all be overcome. In the end, it is a question of societal attention and political will. What is needed is a recognition that, as things stand in Mexico today, promoting UHC would be the single most important policy that could simultaneously enhance social welfare, increase equity and promote growth.

While the case of Mexico is interesting because it is representative of other countries with Bismarckian-type social insurance and segmented health provision, it is important to emphasize that each country is different. Thus, the route towards UHC needs to be adapted to specific circumstances. But, that said, the broader point holds all the same: it is possible to achieve UHC.