Chapter 8

Moving towards a high-quality health system

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Mexico has made significant progress on health in recent years. Life expectancy is up, infant mortality is down and, thanks to the introduction of the programme *Seguro Popular*, health care coverage has risen dramatically. Yet, progress has been slower in Mexico than in other OECD countries. For this reason, Mexico still remains well below OECD averages on a number of key performance indicators, including life expectancy, health spending, cardiovascular mortality and obesity. Low health care spending and high out-of-pocket costs lead to inequalities in access to quality services and have impeded progress. The fragmentation of the health system also must be addressed in order to harmonise performance across sub-systems and states, and enhance its overall level. Obesity is a significant and growing public health problem in Mexico, resulting in high rates of diabetes and cardiovascular death. In order to deliver on the objectives set out for equality of care in the 2012 Pact for Mexico, significant reforms are necessary, including raising health spending in low-spending areas and on prevention, ensuring greater equality of care through a more harmonised system and expanded services, particularly in rural areas.

There has been steady progress across a wide variety of health outcomes in recent years. Nonetheless, Mexico still trails other OECD countries in a number of key health indicators. Life expectancy at birth in Mexico has increased steadily in recent years thanks to the impact of reforms such as the *Sistema de Protección Social en Salud* (including the insurance scheme *Seguro Popular*), which greatly increased access to health care. However, this rise has been slower than in other OECD countries. Overall life expectancy at birth in Mexico in 2015 was 75 years, more than 5 years lower than the OECD average of 80.6 (below the level reached in several countries with similar levels of economic development). Since 2000, the average life expectancy in Mexico has only risen by just over one year, compared to an average gain of more than three years across OECD countries. These lower life expectancies affect both males (72.3 years compared to the OECD average of 77.9 years) and females (77.7 years compared to the OECD average of 83.1 years). A number of factors negatively impact life expectancy in Mexico, including high infant mortality, mortality from cardiovascular disease and high obesity rates.

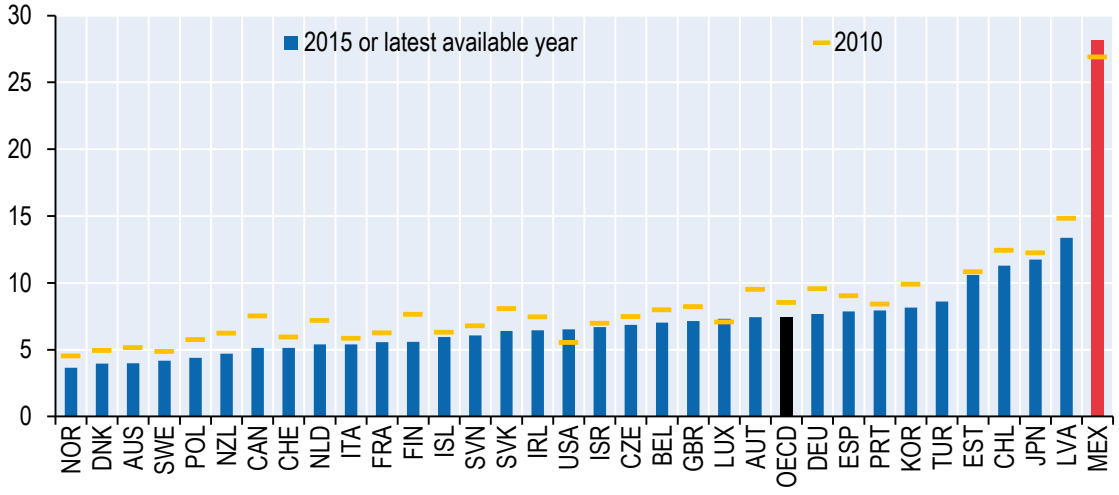
While rates of infant mortality fell by almost 40% between 2000 and 2015, they remain the highest among OECD countries, at 12.5 deaths per 1 000 live births, and three times higher than the OECD average of 3.9 deaths. In developed countries, infant mortality is most often caused by birth defects, premature births and conditions arising during pregnancy, suggesting a need for a greater focus on prenatal care in Mexico.

Mortality rates for patients with cardiovascular disease are particularly high in Mexico. Mexico reported the highest 30-day ischaemic stroke mortality rates of any OECD country at 19.2 deaths per 100 hospital admissions (the OECD average was 8.2 in 2015). Rates for 30-day acute myocardial infarction (AMI) mortality were also the highest among OECD countries and nearly four times the OECD average of 7.5 deaths per 100 hospital admissions (Figure 8.1). These high mortality rates may indicate that patients do not always receive timely or recommended care. A recent national study of AMI care in Mexico revealed that the majority of hospitals were not equipped to treat AMI cases and that delays in treatment were caused in part by patient knowledge gaps. A recent national programme seeks to address these issues and includes additional equipment for the treatment of AMI in hospitals and training for hospital staff to recognise and appropriately treat AMI patients.

Poor diet and the resulting health consequences are also major problems in Mexico. Along with low daily fruit consumption among adults (43.1% compared to 56.8% across the OECD), rates of diabetes are almost double the OECD average (15.8% compared to 7%) and Mexico has the highest number of diabetes hospital admissions (292 per 100 000 population) among OECD countries.

FIGURE 8.1. **MEXICO HAS A HIGH MORTALITY FROM CARDIOVASCULAR DISEASE**

30-day age-standardised mortality rate per 100 admissions of adults aged 45 years and over after admission to hospital for AMI based on unlinked data



Source: OECD (2017), OECD Health Statistics 2017.

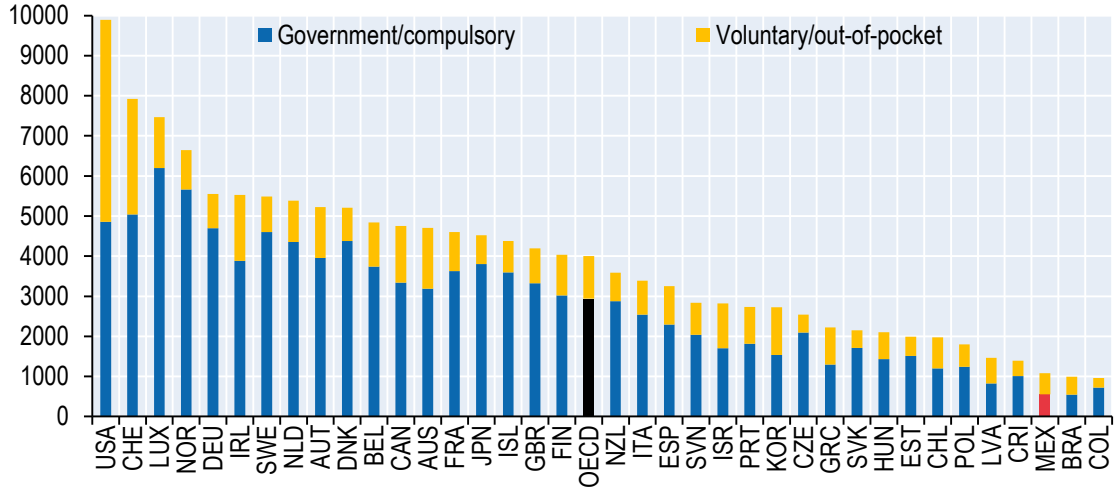
Raising health spending and making sure it reaches those most in need

Mexico continues to make major strides towards achieving its goal of providing a high-performing health system. The *Seguro Popular* programme remains an innovative and inspirational example of how to rapidly cover health care costs for the poor and people working in the informal sector. Thanks to this programme, over 50 million Mexicans previously at risk of unaffordable health care bills now have access to some form of health insurance (Parker et al., 2018). However, despite improvements, Mexico still trails other OECD countries in health care coverage (92.3% in Mexico compared to 97.9% across the OECD). Universal health coverage (UHC) is a necessary first step towards erasing current inequalities in health care access.

Effective access to quality health services for all is held back by low health spending. In 2016, Mexico spent only USD 1 080 per person (adjusted for local living standards), the lowest amount across the 35 OECD countries (Figure 8.2). Mexico also allocates a relatively low share of its national resources to health, as compared to other OECD countries: the 5.8% of gross domestic product (GDP) allocated to health is the third lowest share across OECD countries, and much lower than the OECD average of 9%. Still, the share of GDP spent on health in Mexico is not dissimilar to that of countries with comparable levels of GDP.

FIGURE 8.2. **THE FINANCIAL RESOURCES DEVOTED TO HEALTH ARE LOW BY OECD STANDARDS**

Health expenditure per capita, USD PPP, 2016 or nearest year



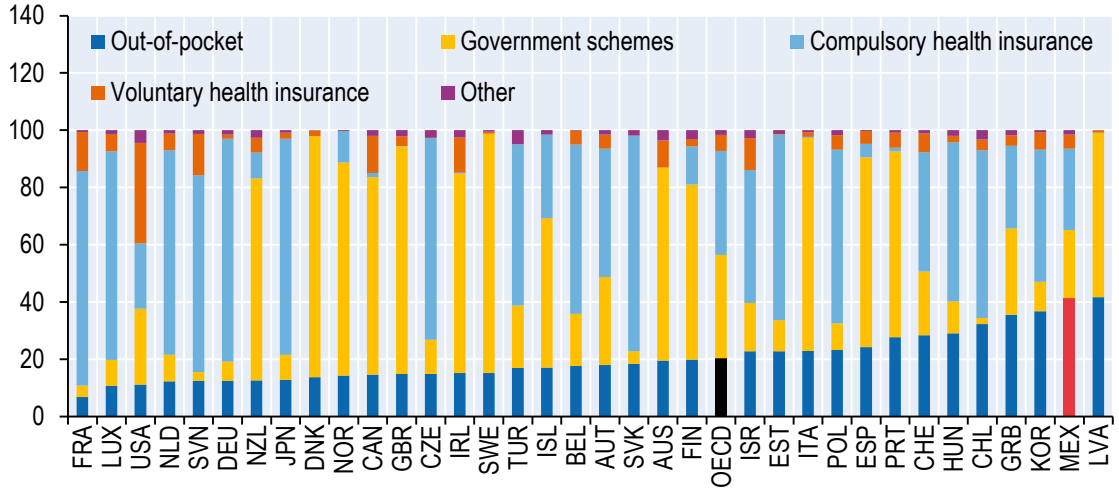
Source: OECD (2017), OECD Health Statistics 2017*, http://www.oecd.org/els/health-systems/health-data.htm.*

Total spending on health, besides being low, is concentrated in the richest states. As a result, wide disparities in spending remain across states and programmes, despite the *Seguro Popular*. These spending disparities translate into disparities in care quality and access. One consequence of this low health spending is an overstretched health workforce. Despite an increasing number of doctors and nurses over the past decade, Mexico still has relatively few health professionals, particularly nurses (2.8 nurses per 1 000 people, compared with an OECD average of 9). The geographical distribution of health professionals is also an issue. For example, while Mexico City has 3.9 physicians per 1 000 people (above the OECD average of 3.4), the number of physicians in other states ranges from only 1.3 to 2.2 per 1 000 people. The high concentration of physicians in larger cities leads to longer waiting times, fewer services, and longer distances to travel for those living in rural communities.

For Mexico to catch up with other OECD countries, investment in health and specifically in rural areas needs to be accelerated. Health spending has grown only modestly in recent years – by 1.4% per year on average since 2009, after adjusting for inflation – which is slightly less than the OECD average. A critical issue to raising more resources for health is to address broader fiscal reforms (see Chapter 2). A large share of resources spent on health comes from out-of-pocket (OOP) payments by households (Figure 8.3). Specifically, OOP payments constitute 41% of health expenditure – the second highest share in the OECD and double the OECD average of 20% – although reliance on OOP payments has decreased in recent years (down from 47% in 2009).

FIGURE 8.3. **OUT-OF-POCKET SPENDING IS VERY HIGH IN MEXICO BY OECD STANDARDS**

Health expenditure by type of financing, 2015 or nearest year



Note: This indicator relates to current health spending excluding long-term care (health) expenditure. Data for France include eye care products, hearing aids, wheelchairs, etc.. Data for the United States include home care and ancillary services.

Source: OECD (2017), OECD Health Statistics 2017, http://www.oecd.org/els/health-systems/health-data.htm.

This high out-of-pocket expenditure for health care is another source of inequality in Mexico. These high costs can become a burden among poorer populations, particularly in the case of people suffering from chronic diseases and illnesses requiring extensive medication. Indeed, 64% of OOP payments are incurred on pharmaceuticals (versus an OECD average of 36%). This high percentage is due both to high co-payments for pharmaceuticals and to high spending on over-the-counter medicines, possibly due to limited access. Costs borne by patients themselves influence access and adherence to treatment. Medicines should ideally be part of the core benefit package and accessible to all patients who need them, regardless of their ability to pay.

In order to continue progress towards a high performing health system, including reduced disparities, additional health spending is needed in Mexico. In addition, a shift towards a better funding mix, one with greater reliance on tax-based financing, seems desirable. This is because social insurance contributions can be less reliable sources of funding than general taxes, particularly with informality in the labour market and fluctuations in employment levels. Current and future spending may also be made more efficient through targeting areas of need such as primary care and chronic disease management. Finally, continued progress towards universal health coverage is needed to ensure access.

Stepping up efforts to reduce fragmentation in the health system

While higher spending on health will surely help, it alone will not be enough to significantly improve health outcomes in Mexico. In particular, continued efforts need to be made to reduce fragmentation in the health system and restructure the system around the needs of patients. Currently, a number of sub-systems for health care provision exist, each determined

by employment status and with various levels of coverage and quality, meaning that large inequalities can exist between professional categories regardless of need.

On the health financing side, greater harmonisation of the benefit packages offered by the various health insurers in Mexico remains critical. Over the long term, a move toward a single national insurance provider applicable to all will be crucial to reduce and eliminate coverage duplication, and to ensure the continuity and quality of careand reduce inequalities. In the short and medium term, service-exchange agreements (*convenios*) among public institutions – which allow patients from one insurer to use the clinics of another – have been an encouraging policy reform. Improving the portability of health insurance, by allowing Mexicans to maintain insurer affiliation after changes in employment, is another policy that could limit the impact of Mexico's fragmented health insurance arrangements and promote continuity of care. Investment in health information infrastructure compatible across sub-systems is another important reform needed to allow for communication and continuity of care.

In terms of health service delivery, efforts to establish universal standards of care are also encouraging. In particular, the 2016 National Agreement towards the Universalization of Health Care Services has the potential to develop shared standards, promote an exchange of services and encourage joint planning of major infrastructure projects for health among public institutions. A greater role for the recently established Quality Monitoring and Improvement Agency is also needed in order to set standards for safe and effective care across sub-systems and ensure equality.

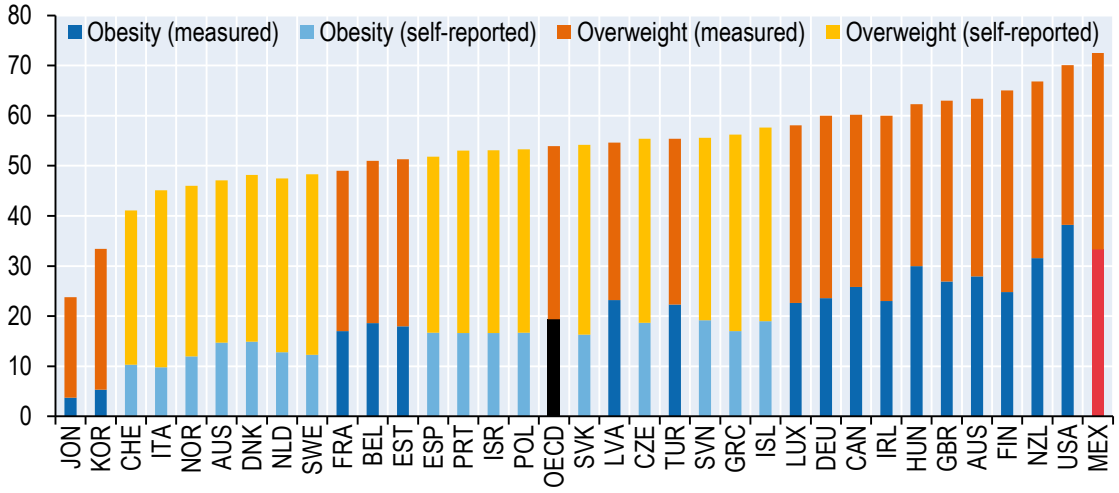
Further tackling Mexico's obesity epidemic

Over the past 30 years, Mexico has become one of the countries in the world most heavily affected by the global epidemic of obesity (OECD, 2016). The most recent data suggest that Mexico has the highest prevalence of overweight and obesity in the OECD, with more than seven persons in ten being overweight or obese (Figure 8.4). In addition, Mexico ranks fourth in adolescent obesity among OECD countries (OECD, 2017).

OECD studies show that one of the most effective policies for preventing obesity and diabetes-related diseases is to put in place a multi-pronged strategy. This may include health education and promotion, regulation and fiscal measures, and lifestyle counselling by family doctors for at-risk adults (OECD, 2010). During the last few years, Mexico has worked to implement such a multi-pronged strategy based on three pillars of policy action: public health, medical care and intersectorial regulation. In particular, Mexico introduced measures to increase public and individual awareness of obesity and associated non-communicable diseases, and the national programme "Healthy Eating & Physical Activity" focused on health promotion and communication. It updated nutritional criteria and guidelines for food and beverages in schools at national level, and enforced a strict norm in advertisement focused on children. It established specialised obesity and diabetes management units. Mexico has also addressed legal and fiscal aspects of overweight and obesity. Most famously, in January 2014, Mexico implemented a new tax levied at a rate of 8% on nonessential energy-dense food (often termed "junk food") with an energy density equal to or exceeding 275 Kcal per 100 grammes, and 1 peso per litre on sugar-sweetened beverages.

FIGURE 8.4. **MEXICO HAS THE HIGHEST PREVALENCE OF OVERWEIGHT AND OBESITY AMONG ADULTS IN THE OECD**

Overweight including obesity among adults as a percentage of population aged 15 years and over, 2015 or nearest year



Source: OECD (2017), OECD Health Statistics 2017, http://www.oecd.org/els/health-systems/health-data.htm.

Mexico should continue working to implement and further refine its National Strategy for Prevention and Control of Obesity and Diabetes (ENSOD). ENSOD does comprise school-based actions, including guidelines for the sale of food and beverages to children. However, as a result of the significant level of informal commerce, the implementation and operation of these guidelines are limited. As part of its strategy, Mexico has also adopted actions to promote regular physical activities in schools. This approach is consistent with current evidence suggesting that comprehensive actions, incorporating interventions on both diet and physical activity, have a positive effect on children's body weight. Nonetheless, school-based interventions should be considered as a long-term investment as any positive effect on chronic diseases starts materializing 30-40 years later.

In addition, Mexico should also focus on adopting a food labelling scheme reporting information in a format easy to understand for the population. Mexico has currently in place a labelling scheme requiring the listing of all major nutrients on food products. OECD analyses suggest that this type of labelling is more difficult to understand and less effective than interpretative nutrition labels like, for example, the traffic-light system (Cecchini and Warin, 2016). An early assessment of the implementation of an interpretative labelling scheme in Chile based on stop signs for products rich in sugar, fat and salt and high in calories shows encouraging results (OECD, 2017). In addition, Mexico should continue investing in interventions aimed at children. Finally, putting in place a strong monitoring system to assess the effects of its policies to tackle obesity seems crucial.

Key recommendations

- **Focus increased investments in the health sector where they are needed most, targeting rural and impoverished areas.**
- **Train more nurses and community workers.**
- **Create a more broad-based health system that is less fragmented, by further expanding the package of care offered by the *Seguro Popular* and, in the medium term, moving towards a single insurance package that applies to everyone and is more portable across different insurance schemes.**
- **Invest in health information infrastructure compatible across sub-systems.**
- **Adopt interpretative food labelling that is easier to understand for consumers.**
- **Upscale efforts to tackle unhealthy lifestyles in children, including by ensuring better implementation of the guidelines of ENSOD.**
- **Building on the excellent work that has been done to monitor the effectiveness of the new tax on non-essential food, upscale efforts to carefully monitor and report the effectiveness of other public policies for the control of obesity and non-communicable diseases such as those mentioned above.**

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