

REACHING THE POOR WITH HEALTH SERVICES

2008

Mexico

Providing Subsidized Health Insurance to the Poor

The Issue

Mexico's Seguro Popular (Popular Health Insurance) program represents an effort to overcome the classic problem in reaching the poor through insurance programs: the difficulty of providing adequate coverage to people working outside the formal sector. Since the better-off are usually employed in factories, governmental organizations, and other institutional settings, they are more likely to have access to greater knowledge of and easier access to health insurance coverage. But the poor tend to work in smaller and poorly-regulated establishments, to be self-employed menial laborers, or to be without work at all as in the case of many female-headed households. Because they are outside the formal sector, they generally do not have access to health insurance through the work place or cannot afford to pay for it, thus enrolling them is far more difficult and they rarely participate.

Mexico had long ago—in the 1940s—solved the problem of providing insurance coverage to formal sector workers, through the typical Latin American arrangement of social security institutions for employees of private and public establishments. These institutions collect premia from employees and their employers, obtain additional funding through subsidies from general government revenue, and use these resources to provide services to the employees covered.

This system worked relatively well for the half of the Mexican population who had access to it. But the other, poorer half of the population was far less fortunate. People in that half were left to seek lower-quality services provided, at a fee, through Health Ministry facilities; or through the expensive and often unregulated private sector. The amount of governmental subsidy they received was well under half

that provided to people with access to social security institution programs.

But the Mexican health system was seriously unbalanced and underfunded. Government health programs were not able to address the challenges presented as the country's health profile shifted in a modernizing economy. Per capita spending on health care in Mexico was less than the average in Latin America. More than half of the money spent on health was out of pocket and higher than in many other Latin American countries. Funding was not distributed efficiently or equitably—close to half of the population was uninsured yet only a third of the federal funds for health went to them. More of the richer people had health insurance coverage while the coverage among the poor was very low—maybe 10%. There was great risk of impoverishment as a result of health spending—two to four million households spent 30% of disposable income on health.

The Approach

The government that took office in 2000 gave a high priority to correcting this imbalance. To do so, it introduced a set of reforms that featured a new health insurance program, Seguro Popular (SP), for all those not covered by the existing social security plans. The purpose of the voluntary program was, and is, to provide these people with subsidized insurance coverage comparable to that available to social security beneficiaries.

The Health Ministries of Mexico's thirty-two state governments have primary responsibility for identifying, enrolling, and serving eligible SP participants. The program was designed to focus on the poorest families first. Regular premia



payments are subsidized on a sliding scale by the state, and the families from the poorest 20% of the population do not pay. Participants are entitled to treatment *at no additional cost* for some 250 interventions at specified institutions, (mostly the same state government facilities at which participants had previously paid for such services as had been available to them). SP participants are also eligible for seventeen interventions at a network of higher-level tertiary care institutions operated by the federal and state governments.

The gap between income from premium payments and the program's total cost is covered by government subsidies. The majority of the funding comes from the federal government, through payments to the state governments, allocated through a formula that factors in the level of development of the state, with poor states receiving more than better-off ones. The formula also accounts for number of families enrolled, giving states an incentive to improve the quality of services and increase the number of participating families. The state governments bear the remaining costs from their own resources.

The financial requirements of the SP program constitute a primary reason for the recent increase of the previously-limited volume of federal government resources allocated to health. For example, the budget of the Federal Health Ministry has increased by about 53% between 2000 and 2005, largely attributable to the program's implementation. Including 2006, the increase was close to 66.5%, an average of 10.7 percent a year from 2000 through 2006. Affiliation is the driver of annual increases in funding via the federal quota. Universal health insurance is projected to add equivalent of one percentage point of gross domestic product (GDP) to public investment in health.

Ensuring Participation by the Poor

The SP program aspires to universal coverage by 2010, reaching better-off and poor uninsured people alike. However, it is designed to ensure that disadvantaged are served first, rather than last (or never) as occurs in many universal coverage programs.

The legislation underlying the program calls for increased coverage among deprived groups to receive highest priority during the seven-year (2004 through 2010) rollout period, up to 14% affiliation per year. To move this statement of intent beyond the rhetoric, the program design includes three related measures. One is a scale of premium rates that is graduated by economic status and exempts the poor from payment. The second is a mechanism permitting acceptably

accurate identification of poor families that qualify for premium subsidies or exemptions. The third is a system for paying implementing agencies that gives them an incentive to focus on enrolling the poor families thus identified.

Subsidized Premia for the Poor. The system is based on prepayment for a package of services that will expand as demand and funding permit. The size of premium payments for participation in the program, which is voluntary, varies according to the participants' economic status. Families pay up to 5% of disposable income (defined as total spending after basic needs are covered). The size of the premium falls and size of government subsidy rises as one moves down the economic ladder, with people in the poorest 20 percent of the population paying nothing at all.

Identification of the Poor. The states have several options available for identifying the people qualifying for different levels of subsidy. One is to follow the lead of the already-existing, highly-progressive Progres/Oportunidades Program, described more fully in a separate brief in this series, whose enrolled (in principle, also from the poorest 40% of the population) are automatically eligible for SP coverage at no cost to them. Another is to apply a similar method for identifying prospective beneficiaries, similar to that of Progres/Oportunidades, that has been prepared by the SP program itself. Alternatively, the states are free to use the approach taken by one of several other federal subsidy programs other than Progres/Oportunidades, or to enroll all members of specified groups without evaluation of the groups' individual members.

The Progres/Oportunidades and SP approaches feature use of a "proxy means test," already described in other publications in this series (the briefs on Mexican cash transfers and on Colombia's proxy means test). Such a test involves identifying the poor not on the basis of income or expenditures, until recently the standard measure of economic status, but rather from information about the assets of households and the people living in them. Field workers score each item on the basis of guidelines developed through statistical studies of household economic status, sum the results, and compare the overall outcome with those of other members of the population. The amount of premium due is based on where the family concerned fits on the economic spectrum thus identified: the lower the family is, the less it pays.

The proxy means test is applied only to members of poor villages, who may not have affiliations to other social service programs, identified on the basis of census information

about things like employment conditions, civic amenities, and educational levels. The result is thus a two-stage process, involving first the determination of poor communities, and then the identification of the poorest people within those communities.

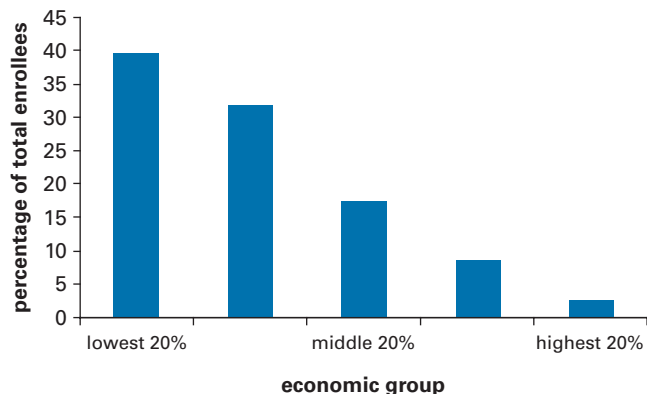
Incentive for Enrolling the Poor. The federal SP support provided to state governments *largely and gradually replaces the assistance it had earlier given* on the basis of prior-year levels and the number of state health workers. This shift makes the volume of federal assistance dependent on the number of people that the states serve, rather than on the number of people they employ and facilities that they operate. The result is an incentive for the states to enroll as many people as possible in SP, in order to maximize and stabilize the amount of their federal subsidies. The fact that the poor do not have to pay premia, unlike higher-income groups, make them likely candidates for early enrolment than the better-off people who will have to be persuaded to pay for their participation. The poor thus become potentially the most lucrative enrollees from the perspective of the administering agency, rather than the least attractive group to administrators in other programs because of the greater difficulty and expense often involved in reaching them.

The Initial Record and Future Prospects

By the end of 2005, the second of the seven years in the roll-out period, SP had enrolled around 11.5 million people, just under 20% of the 65–75 million or so Mexicans not covered by the social security system. Around 40% of these enrollees were in the poorest 20% of the population, compared with fewer than 3% in the population's best-off 20%. (See Figure 1.) By 2004, insurance coverage among the poorest 20% of Mexican families had risen to 37%, up from 7% in 2000. SP participants in need of health services were significantly more likely to obtain them than were those who did not participate.

This record has made SP far more progressive than the social security programs it is designed to complement, as the social security program beneficiaries remain heavily concentrated among the higher income groups. On the other hand, the SP initial record has been notably less progressive than that of the Progres/Oportunidades program of conditional cash transfers. As shown in the separate brief in this series dealing with Progress/Oportunidades, that program had reached some 80% of the poorest 20% of the Mexican population seven years after its 1998 initiation; and nearly 60%

Figure 1. Enrollment in Mexico's SEGURO POPULAR Program by Economic Level



Source: Gakidou et al., 2006

of its beneficiaries at that time were in this poorest group.

To some extent, this difference can be attributed to the differing objectives of the two programs: Progres/Oportunidades was intended for only the poorest 20% of the population, while SP is designed to reach all uninsured, many of whom lie outside this group. Two other possible considerations relate to the differences in the amount of time the two projects have been in operation and the income levels of the states and the fact that they joined the program at different times. By some accounts, another significant factor has been the decision of some states to follow less precise beneficiary identification measures than that employed by the centrally-administered Progres/Oportunidades. (The Government of Mexico's Federal District, for example, opted to use the notoriously inaccurate system used by a long-standing program for the distribution of subsidized milk.) To the extent this is the case, it would illustrate a disadvantage of decentralizing program design in a setting where local authorities appear less progressive than central ones.

In the two or three years since collection of the above-cited data, the SP program has moved to the approximate half-way point in its seven-year roll-out period. What about the future? While this is by definition unknowable, informed observers point to two of the principal challenges that SP is likely to face:

- First, continuation of the federal government's provision of the large volume of funds that the project will require over the years ahead. National elections led to a change of government in late 2006. One can rarely take it for

granted the willingness of any new government to continue a project created by and closely associated with its predecessor. Nonetheless, one of the first decisions by the new government was to insure all children born as of the start of the administration, thereby indicating its commitment to the program.

- Second, the interest of people outside the poorest 20% to pay the premia required of them to participate in SP. These people will constitute an ever increasing proportion of the additional people who will have to be enrolled in the coming years if SP is to meet its objective of universal care. Failure to attract these people would leave SP in a highly unusual, possibly unique situation of being a universal coverage program whose failure to completely achieve its objective leaves it as an initiative that benefits the poor far more than the better-off.

This brief is intended to summarize good practices in reaching the poor with health, nutrition, and population services. It is based primarily on a 2006 series of six articles on health reform in Mexico published in the British medical journal *The Lancet*, particularly the first and fifth in that series: Julio Frenk *et al.*, “Comprehensive Reform to Improve Health System Performance in Mexico,” vol. 368 (October 28, 2006), pp. 1524–36; and Emmanuela Gakidou *et al.*, “Assessing the Effect of the 2001–06 Mexican Health Reform: An Interim Report Card,” vol. 368 (November 25, 2006), pp. 1920–35. Other source material includes: Felicia Marie Knaul and Julio Frenk, “Health insurance in Mexico; Achieving universal coverage through structural reform, *Health Affairs*, 2005, 24(6)1467–1476, and *Salud México 2001–2005*, Secretaría de Salud de México, available at: <http://evaluacion.salud.gob.mx/>. Additional information came from John Scott, “Seguro Popular Incidence Analysis,” in The World Bank, *Decentralized Service Delivery for the Poor* (Washington: The World Bank, 2006), vol. II, pp. 147–66. (Available electronically at: <http://siteresources.worldbank.org/INTMEXICO/SPANISH/Resources/VolIIChapter3.pdf>.) The editors thank Felicia Marie Knaul for very helpful comments on an earlier draft.

