Efforts to establish social health protection systems: the cases of countries in Latin America

Different strategies towards universal health coverage

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Topics

Content

- General overview
- Health system reforms in Chile
- Health system reforms in Brazil
- Health system reforms in Mexico
- Concluding remarks and lessons learned
- Comparative analysis and discussion

Historical background

- 1492: Christopher Columbus lands in Hispaniola
- 1500-1550: European conquerors occupy relevant parts of Latin America
- 1800-1820: Independence of most colonies in Latin America
- 1820-1850: Bounder wars and Internal struggles between “conservative” and “liberal” local elites largely influenced by Europe
- 1850-1900: Consolidation of national states

Latin America: Historical Overview

- Year of indepen-dence

Latin America: Historical Overview

Central America: Political regimes in 1900 and 2000

Historical background

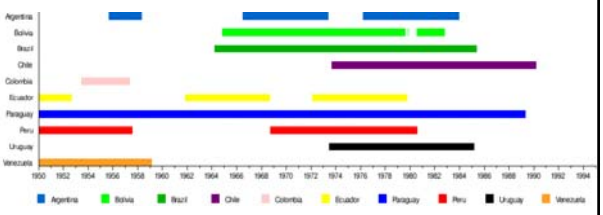
- 1900-1920: Emerging industrialisation and revolutionary movements
- 1920-1950: Emerging economic and social development with rapid political and societal changes
- 1950-1990: Period of political authoritarism and guerrilla conflicts; under strong influence of the Cold War
- 1970-1990: Economic crisis (petrol), structural adjustment and predominance of “neoliberalism”
- Since 1990: Sustainable democratisation and economic development; catch up of social policy

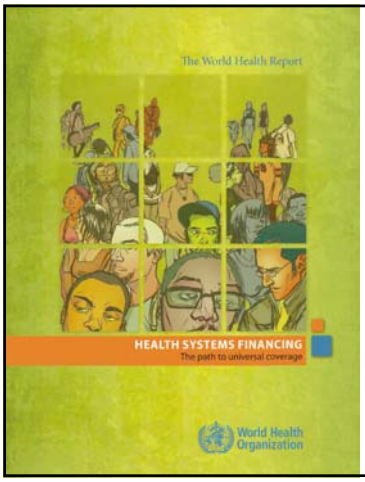
Latin America: Historical Overview

South America: Political regimes in 1900 and 2000

Latin America: Historical Overview

Periods of dictatorship





Health Systems financing: The path to universal coverage

http://www.who.int/whr/2010/whr10_en.pdf

Gesundheitsfinanzierung

The World Health Report

HEALTH SYSTEMS FINANCING

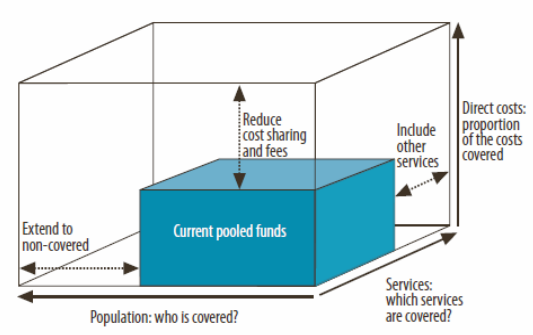
The path to universal coverage

Recognizing this, Member States of the World Health Organization (WHO) committed in 2005 to develop their health financing systems so that all people have access to services and do not suffer financial hardship paying for them (4). This goal was defined as universal coverage, sometimes called universal health coverage.

In striving for this goal, governments face three fundamental questions:

1. How is such a health system to be financed?
2. How can they protect people from the financial consequences of ill-health and paying for health services?
3. How can they encourage the optimum use of available resources?

Universal health financing coverage



Source: World Health Report 2010, p. 12

Key features of health financing systems

- Universal coverage: Everybody has access to adequate health care that is affordable for him/her ⇨ nobody should be excluded, benefits are the same for all and should depend on need and not on ability to pay
- Fair financing: Requires prepayment and broad risk pooling in order to prevent people from impoverishment due to bad health
- Comprehensiveness and linkage with other branches of social protection

Health systems in Latin America

Models of health financing

Social Health Insurance (Bismarck): Covering 10 –20 % of the population in many Latin American countries, often vertical integration

State model (Beveridge): Public, tax-borne financing of health services for the poor, mostly vertical integration

Market model: Private health insurance for the better off, usualy direct payment mainly for poorrer population groups

Micro-insurance: Small, self-administered health-insurance schemes of communities, cooperatives, professional groups etc.

Health systems in Latin America

	Integration of institutional functions	
Integration of populations	***Vertical integration***	***Separation***
Horizontal integration	**Unified public model (e.g. Cuba, Costa Rica)**	**Public contract model**
Segregation	**Segmented model (most Latin-American countries**	**Atomised private model (e.g. Argentina, Paraguay)**

Health system Chile (1)

- First Western nation outside Europe with comprehensive medical coverage (since 1918)
- Social security legislation in 1924 and 1925
- Development into a National Health Service (SNS) until 1981
- The State managed financing and provision of health care
  - Services free of charge
  - 90 % of hospital emission
  - > 85 % of out-patient treatments
- Financing:
  - 61 % fiscal budget
  - 26 % social security transfers of the beneficiaries
  - out-of-pocket payments

Health system Chile (2)

Socio-political background:

- Dictatorship of Augusto Pinochet (1973-1990)
- Sustainable cut back of all public expenses
- Strong austerity policy particular in social sectors
- Worldwide predominance of neo-liberal economic ideology (Milton Friedman)

Core characteristics of the reform

- Lack of regulation and control of the private health insurance sector
- Bottom-down approach without participation
- Lack of transparency and consumer advocacy

Health system Chile (3)

One of the most radical socio-political changes worldwide:

- Foundation of FONASA (Fondo Nacional de Salud - National Health Fond) as single **public** health insurance scheme
- Private insurance companies accepted as providers of social security services (ISAPREs – Institutos de Salud Previsional - Health Provision Institutes
- Decentralisation: Split up of the National Health Service (SNS) into 27 regional Health Services
- Municipalities become responsible for primary health care

Health system Chile (4)

- Health insurance remained mandatory - minimum contribution 7 % of taxable income
- In theory, dependent and independent workers have the choice between public and private health insurance
- Public health insurance (FONASA) is compulsory, private health insurance (ISAPRE) is voluntary and requires an active step
- ISAPREs offer individual, risk-related insurance contracts

Health system Chile (5)

Objective: Competition between public and private health insurance (Solidarity versus equivalence)

Premises for health financing:

- Health insurance remained mandatory - minimum contribution 7 % of taxable income
- In theory, dependent and independent workers have the choice between public and private health insurance
- Public health insurance (FONASA) is compulsory, private health insurance (ISAPRE) is voluntary and requires an active step

Health system Chile (6)

- ISAPREs calculate insurance contributions according to expected expenditure:
  - The contribution is the product of the basic tariff of each plan and corresponding risk factors
  - Contribution was higher for women in fertile age
  - Contribution rises constantly with the age of contributors and dependents
- No obligation to contract enrolees: ISAPREs can reject applicants
- Contracts were renewable every 12 months, now every 24 months

Health system Chile (7)

Healthcare provision in Chile

Double structure:

Public

IPC (Government hospitals):
- Situation of shortage
- Waiting times
- Reduced "hotel"-quality

OPC (policlinics):
- Limited working hours
- Waiting queues
- Scarcity of resources

Private

IPC (private hospitals):
- Excellent facilities
- Negligible waiting times
- Good "hotel" service quality

OPC (private clinics):
- Flexible opening hours
- Short waiting queues
- Good service

Health system Chile (8)

Basics of health-insurance competition in Chile:

Equitable resource generation ⇨ income-related and, hence, exogenous determination of contributions

Effects of applying the principle of equivalence on the expenditure side:

1. Variable cost coverage
2. Partly high and widely unforeseeable co-payments
3. Inverse relation of income and OOP: The lower the household income, the higher the co-pays
4. Negligence of epidemiologic trends and needs

Health system Chile (9)

- **ISAPRE cost-sharing policy:**
  - Broad variability of financial burden: 0 - 91 %
  - Practically unforeseeable
  - Significant limitation of financial protection (depth of coverage)
  - Socially unfair
    - In absolute terms as a share of income
    - In relative terms because of durch inverse relationship to income
  - Cost-coverage policy does not correspond to the challenges of epidemiologic transition

Health system Chile (10)

FONASA contracting and revenue collection

- Collective, risk-independent insurance contracts
- Contributions depend exclusively on household income / purchasing power (up to an upper ceiling)
- Redistribution mechanisms according to the principle of solidarity:
  - Higher income ☛ lower income
  - Young ☛ Old
  - Households without / with few children ☛ Households with many children
  - Male ☛ Female
  - Economically active ☛ inactive population groups
- Obligation of contracting for FONASA ⇨ cannot refuse applicants
- Indefinite duration of contracts

Health system Chile (11)

Combining Beveridge and Bismarck

- FONASA covers also the poor and indigents
- Mixed financing from social health insurance contributions **and** tax revenue
- Grouping of beneficiaries according to socio-economic situation (groups A, B, C, and D):
  - Contributions depend exclusively in income (at least up to a certain ceiling)
  - Cost-sharing: Co-insurance for healthcare and exemption according to income:
    - Groups A and B: 0 %
    - Group C: 10 %
    - Group D: 20 %

Health system Chile (12)

Tax revenue for healthcare of the poor

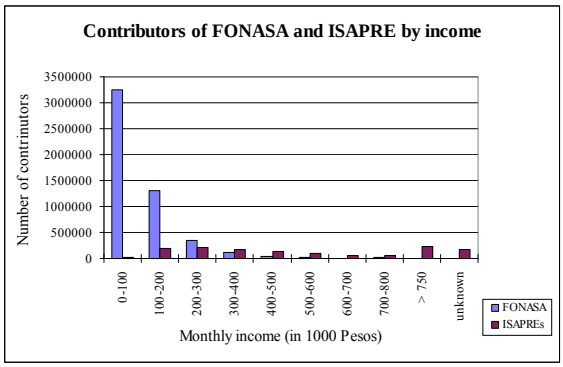
- Decentralised identification of the poor by municipalities and health facilities
  - 2008: Approx. 3.8 million Chileans (out of 17 million)

In 2000: Data exchange and cross check between FONASA and Ministry of Finance: 500,000 indigents (group A) were paying taxes - average taxable income 4.500 US$ per year

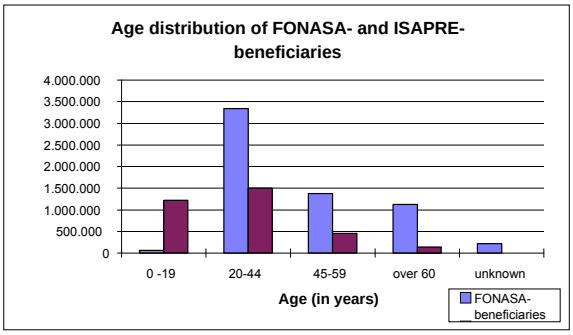
Health system Chile (14)

- Cream skimming
  - In 2000, 90 % of FONASA beneficiaries earned less than 400 US-$ and 66 % even less than 200 US-$ a month
- Risk selection
  - In 2008, the market share of ISAPREs was 16.5 % out of which only 10 % were above 60 years
  - Less than 4 % of the Chileans over 65 years belong to an ISAPRE
- Growth of individual health expenditure:
  - rising contributions to avoid worse coverage
  - high co-payments for poorer ISAPRE beneficiaries

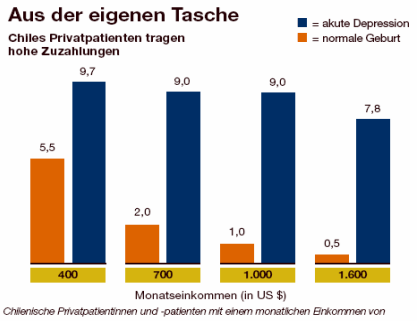
Health system Chile (15)



Health system Chile (16)



Health system Chile (17)



Chilenische Privatpatientinnen und -patienten mit einem monatlichen Einkommen von 400 US-Dollar zahlen für die Therapie einer Depression 9,7-mal so viel zu wie gesetzlich Versicherte. Selbst bei 1.600 US-Dollar Monatseinkommen beträgt dieser Faktor noch 7,8. Privatversicherer schrecken mit diesem Vorgehen chronisch Kranke ab.

Comparative analysis of out-of-pocket payments by ISAPRE- und FONASA-beneficiaries for selected treatments

Health system Chile (18)

- Multiplication of transparency lack on health market
- Negative incentive for prevention in the private sector:
  - The ISAPREs can get rid of their users before they become expensive
- Low incentive to anticipate the consequences of demographic and epidemiological changes
- Quality skimping by inverted proportionality of co-payments to income

Health system Chile (19)

Outcomes

- Loss of transparency instead of transparency gains on the health market
- Typical problems of the market model:
  - Negative incentives for prevention in the private Sector: ISAPREs can expulse their clients before they become cost intensive
  - Low incentives for developing strategies to cope with he consequences of demographic und epidemiologic transition
  - High administration costs (up to 19.5 % for ISAPREs)
  - Unfair financing due to inverse Relation of co-payments and income
  - Lacking sustainability: Market share of private health insurance decreases during economic crisis

Health system Chile (19)

Re-reform 2005: Plan AUGE (Acceso Universal con Garantías Explícitas = Universal Access with Explicit Guarantees)

Implementation of certified healthcare guarantees for all citizens to access health services within a certain time frame and with capped OOP
Incremental approach: Start with four diseases, meanwhile > 80 epidemiologically relevant health problems
All health insurance schemes and all health facilities are enforced to comply
System-wide approach in order to reduce inequities between subsystems

Re-Reform 2005: Plan AUGE

Regulation of waiting times ➲	Challenging for the public sector
Capping of co-pays to ➲ maximum two monthly incomes per year	Particularly relevant for the private sector

Health system Chile (21)

Re-Reform 2005: Additional reform elements

- Separation of functions in the public health sector
- Implementation of a supervisory board for all health-insurance institutions
- Empowerment of patient and beneficiary rights
- Creation of additional complaint services

Health system Chile (22)

Lessons to be learned from Chile:

- Competition between health insurance schemes does not automatically contribute to containing costs
- Competition between public and private health-insurance schemes is complicated and inefficient ➧ ***Disincentives***
- Strong regulation and adequate incentives indispensable
- Combining tax-borne and contribution-borne revenue generation is practically feasible for achieving **universal coverage**
- Co-pays are socially unfair and discriminate against the ill
- Exemptions from co-pays are possible but require effective control (e.g. cross check of data)

Health system Chile (23)

Conclusions

- Neoliberal, market-driven reforms bring about considerable need for subsequent adaptations and improvements
- Reforms implemented during the last quarter of the 20th century have deteriorated access and financial equity and aggravated social inequality
- Readjustments are difficult to eke out and to achieve, and they can overcome only rudimentally the damage originated by the implementation of neo-classical thinking in the real world

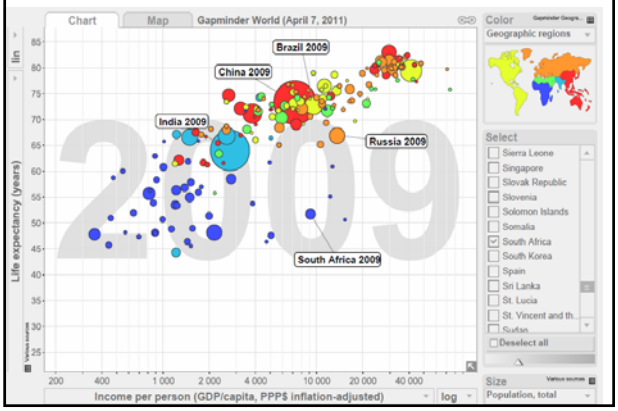
Healthcare System in Brazil Sistema Único de Saúde – SUS

Unified Health System

Brazil: Historical development

- Portuguese colonialism (1500–1822)
- Imperial phase (1822–89)
- Old Republic (1889–1930)
- Vargas dictatorship (1930–45)
- Democratic instability (1945–64)
- Military dictatorship (1964–85)
- Democratic transition (1985–88)
- Democracy (1988–2013)

GDP per capita and life expectancy, BRICS



Population indicators in Brazil			
Population (2010)			190.732.694
% under 18 years			29,6%
% ≥ 60 years			11,3%
Life expectancy	male	female	total
Brazil (2011)	70,6	77,7	74,1
Northeast (2009)	66,9	74,1	70,4
South (2009)	71,9	78,7	75,2
Fertility rate (number of children per woman) 2010			1,9
Infant mortality (per 1000 life births)		1995	2010
Brazil		31,9	15,3
Northeast		50,4	20,1
South		17,5	11,3

Economic indicators of Brazil			
GDP 2011 2,47 trillion US$			
BIP per capita US$ ppp (2011)			11.640
Share of poverty	**2002**	**2008**	**2011**
Extreme poverty (%) (<1,25 US$/day or <70 Reais/month = <25 Euros/month)	13,2	7,3	*6,1
poverty (%) (<2,5 US$/Tag)	32,4	22,6	20,9
Human development index (GER 0.920)	**2000** 0.669	**2005** 0.699	**2012** 0.730
Gini index on income distribution	0.572	0.552	0.508
(GER 0.290) (0= equal distribtrion; 1= maximum income concentration			
Income of the 1st / 5th quintile		**2001** 24	**2011** 16,5
*According to the 2010 census 16 Millionen Einwohner Source: IBGE, PNUD, WB, CEPAL			

Setting up the Brazilian healthcare system

- 1919: National Department of Public Health (Departamento Nacional de Saúde Pública): Coordination of preventive health services in rural areas, fight against infectious diseases, agreements with federal states
- 1930: Ministry of Education and Public Health (MESP)
- 1937: Structural health-system reform: Federal Health Departments in eight 8 regions; 12 National Health Services; Nacional Health Conferences
- 1953 – Ministry of Health (⅓ resources of MESP): Public health campaigns (malaria, leprosy, tuberculosis, vaccinations, health surveillance)
- 1956 – National Department for Rural Endemics (Departamento Nacional de Endemias Rurais - DNERu)

Setting up the Brazilian healthcare system

- 1923: Creation of the Railway Pension and Retirement Fund at enterprise level
- 1933: Pension and Retirement Institutes with compulsory affiliation according to professional category and for autonomous public companies related to the Ministry of Labour
- 1960: Organic Social Provision Law implementing unitary pension benefits for urban workers independently from the labour category 1966: Incremental expansion of pension coverage
- 1972 Implementation of FUNRURAL providing medical assistance in rural areas
- 1974: Foundation of the Ministry of Provision and Social Assistance 1975: National Health System Law determines the separation of responsibilities in health and the dichotomy of preventive and curative care + of public health and medical assistance between MoH and MPSA

Health sector reform in Brazil in the 1980es

- Civil society health movement (Movimento Sanitário) in the context of democratisation during the 1980es claiming for the universal right to health
- Democratisation of decision-making processes in health
- Structural reform of the health sector after the end of the military dictatorship:
- 1988: Approval of a new federal constitutional called „ Constitution of Civil Rights“ defining health as
  - universal civil right and
  - duty of the State
- 1990: Establishment of the Unified Health System (Sistema Único de Saúde – SUS)

Brazil: Set up of Social Health Protection

- 1933/34: Set up of Social Provision schemes (Previdência Social)
- 1943: New labour legislation consolidating prior attempts to set up social protection for formal-sector workers
- Until 1988: Further development of Bismarck-like social health protection schemes
- Maximum coverage by SHI 50 %: Due to the size of the informal sector half of the population does not have access to the healthcare system

Brazil: Background

- Recent political history of Brazil, with a military dictatorship until 1985 ⇨ Conditions for a strong civil-society movement
- Political movement mounted a powerful drive for health reform ultimately resulted in the Unified Health System (Sistema Único de Saúde - SUS)
- Long history of public health ⇨ Health is basically considered a human right and defined beyond biomedics including social determinants, poverty reduction, education, and prevention.

Unified Health System – Sistema Único de Saúde (SUS) – Brazil

- System change from Bismarck-like social health insurance to a Beveridge-type national health service
- **Tax-borne healthcare system with free access for all citizens – National Health Service**
- **Population Coverage: 100 %**
- SUS improves population access to the healthcare system for relevant population groups formerly excluded from health care and deprived from the right to health

Principals of the SUS

- **Universal access to comprehensive care**: Health promotion, prevention and healthcare provision at all levels of care
- **No detailled list of services:** The SUS benefit package comprises outpatient and inpatient care at all levels of complexity, preventive and promotive procedures, and a broad spectrum of health services dtarting from immunisations to transplants
- A **limited scope of medicines** is provided free of charge in public healthcare facilities, but cost-free access to drugs is guaranteed for some public health programmes such as HIV/AIDS, tuberculosis and others

Principals of the SUS

Shared decentralised responsibility: Federal Republic (1)-, federal states (26+ DF), and municipalities
Social participation through 5 560 **health councils:** equal representation of users (50%) and providers / government representatives (50%)
http://conselho.saude.gov.br/

Every four years health conferences at all three government levels

Federal health conferences define objectives for the SUS

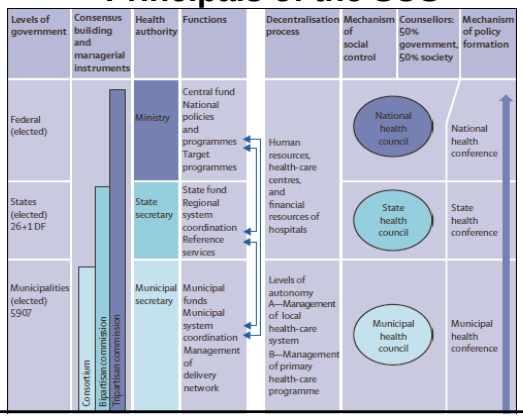
Principals of the SUS

- **Decentralisation of the healthcare system:** shared responsibility of Federation, federal states and municipalities
- After decentralisation, today the 5.560 municipalities are providing primary health care
- In cooperation with the 26 federal states (+ DF) they are responsible for ensuring availability of secondary and tertiary care

Health care is guaranteed through public and private providers:

- 42.000 public municipal health centres for primary care
- Private and public specialised policlinics, laboratories and hospital contracted by the SUS (two out of three hospital beds and most diagnostic facilities are privat)
- **SUS yearly provides:** 500 million consultations; 2.8 billion outpatient services; 11 million inpatient treatments; 236,000 heart surgeries, 23,397 organ transplantations, etc.

Principals of the SUS



Principals of the SUS

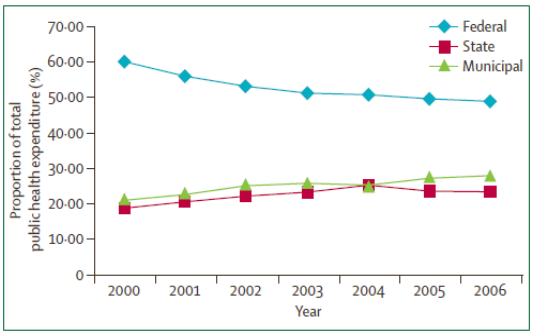
Tax-borne financing of the SUS

SUS financing is shared among three government levels: Currently, the Federation bears 45 %, the federal states 26%, and the municipalities 29 % of SUS expenditure.

Total public health resources and expenditure according to level of government in %:

Govern-ment level	Share of total public revenue	Share of public health expenditure	
	2009	1990	2008
Federation	56	73	45
Federal States	25	15	26
Municipalities	19	12	29
Total	**100**	**100**	**100**

Brazil



Principals of the SUS

- **The implementation of the SUS occurred in a unfavourable context**
  - Lack of adequate financing for extending the range of SUS beneficiaries
- **SUS is underfinanced:**
  - Public expenditure on health: 3,7 % of GDP (GER 8,9%)
  - Public expenditure on health as share total expenditure on health: 45 % (GER 77 %)
  - SUS per-capita expenditure: = 420 int. US$ PPP
  - Total expenditure on health per capita = 970 int. US$ PPP ≙ 8,4 % BIP (BRD 4.338 US$ PPP ≙ 11,6% BIP)
- Quality deficits and access constraints / waiting queues still exist
- **Segmentation:** 25 % of inhabitants (47 million people) have additional private health insurance (65 % formally employed covered through their working place

Principals of the SUS

Primary health care in Brazil

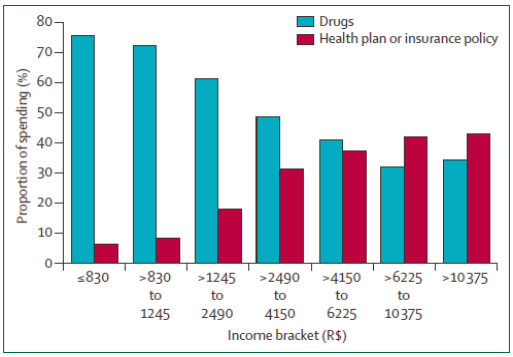
- Primary health care (PHC) played an important role during in the implementation of the SUS; since the end of the 1990es, family health is the PHC strategy
- The f**amily health strategy** is implemented in public health centres with multi-professional teams composed of:
  - one general practitioner
  - one trained nurse
  - two auxiliary nurses
  - 5 - 6 health workers from the neighbourhood: Agentes comunitários de saúde - ACS (Community Health Workers)

Principals of the SUS

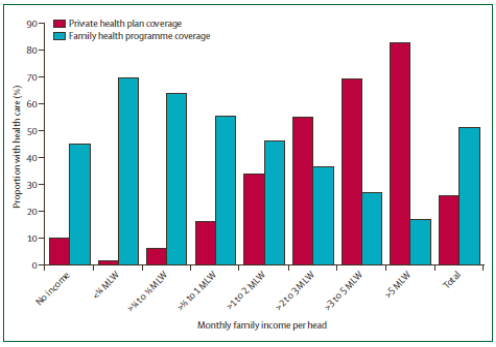
Challenges of the SUS

- Ineffective tax collection ⇨ relevant evasion
- Regressive tax system: > 70 % of tax revenue derives from indirect taxes
- Insufficient financial resources:
  - Total expenditure on health (THE) as % of GDP: 8.9
  - Total expenditure on health per capita: 1.121 US$
  - OOP 22 %
- Parallel private sector for the better off

Brazil



Brazil



Health system Brazil

Conclusions

- Politically driven health-sector reforms allow for comprehensive and integral approaches
- Social protection goes beyond heath coverage
- It is possible to resist strong, predominant trends such as neoliberalism and commercialisation if strong political and societal will exist
- Tax-borne national health services provide universal coverage
- Equity and fairness of financing of national health services depend on the underlying tax system

Onset of the Mexican Health System

Incremental set up of social health protection in Mexico:

- Obvious influence by the German SHI model (Ernst Frenk) designed for the formal sector
- Complementary implementation of health services for informal sector workers and poor who were not covered by formal-sector schemes
- Expansion of the Bismarckian approach to civil servants and formal public-sector workers
- Upgrading of government health facilities
- Set up of a complementary health-insurance pillar for excluded population groups

The Mexican Health Financing System

Fragmentation of Mexican SHP system:

- Formal-sector employees (IMSS)
- Civil servants (ISSSTE)
- Special government regimes (oil company, military)
- Private sector (better off and often the poor)
- Rest of the population - mainly unemployed and informal sector workers attended in the public health centres and hospitals funded and supervised by the MoH and managed at state level

The Mexican Health Financing System

Bismarck model since 1943
Social health insurance: ≤ 55 % of the population

+

Beveridge system - Ministry of Health: 35 % ⇨ Seguro Popular

+

Market system - Private health insurance: ≤ 10 %

IMSS: Year	Enrolees	Pop.share
1944	355 527	
1945	533 555	
1946	631 099	
1947	747 745	
1948	834 084	
1949	894 603	
1950	973 085	3,77%
1955	1 576 196	
1960	3 360 389	
1965	6 815 685	
1970	9 772 492	20,27%
1975	16 337 593	
1980	24 125 307	
1985	31 528 583	
1990	38 575 140	47,51%
1995	34 323 844	
2000	45 053 710	46,21%
2005	44 531 666	
2010	52 310 086	46,57%

Mexican health care system until 1984

Functions	Public Social Security Schemes for Formal Sector Workers and Families	Uninsured	Affluent
Responsibility for services and typical coverage of total population (percent varies each year according to employment conditions)	IMSS for private formal sector employees 40%	MoH 46%	Private insurers 3%
	ISSSTE for government employees 9%		
	SEDENA & SESMAR for armed forces 2%		
	Petróleos Mexicanos (PEMEX) for oil workers less than 0.5%		
Financing	Social Security schemes were financed from three sources: the employer, the government, and the employee. The proportions paid by each source were different for each scheme.	Government (mainly federal with some state contributions)	Private funds
Health care providers	A network of clinics and hospitals staffed and operated by the different schemes	A network of clinics and hospitals staffed and operated by the MoH. Some states and municipalities had developed their own network.	Private network
		The IMSS-COPLAMAR program, which was financed by the MoH and operated by the IMSS, provided health care mainly in rural areas.	
Access to services	Free at point of service (including medications)	Free at point of service (including medicines for priority programs)	Varied
Per capita expenditure	Large variations depending on the type of scheme	Varied by state	Varied

doi:10.1371/journal.pmed.1000124.t002

Homedes N, Ugalde A (2009) Twenty-Five Years of Convoluted Health Reforms in Mexico. PLoS Med 6(8): e1000124. doi:10.1371/journal.pmed.1000124
http://www.plosmedicine.org/article/info:doi/10.1371/journal.pmed.1000124

PLOS | MEDICINE

Health care delivery for the uninsured after the creation of SP

Functions	Uninsured Not Affiliated to SP (Remains Basically Unchanged)	Affiliated to SP
Responsibility for services	State health system	State Health System. The System for Social Protection for Health (SSPH), also referred to as SP, decides the services to be provided to the insured, and the protocols to be followed
Financing	Federal government, state governments, and user fees	The financing formula is very complicated. The MoH and the states make a fixed per family contribution. Enrolled families contribute to the system based on a sliding-fee scale. The federal government allocates extra funds to the most marginalized states.
		Family premiums are waived for families in the lowest two income deciles and for those in the third lowest income decile with a child under 5 y.
Health care providers	A network of state health services: all public facilities to be managed by the state health secretary.	States can decide, usually a network of private and public facilities and providers.
	The majority of state employees are federal employees; states have some control over human resources, programs, and finances	Often the state is unable to provide mandatory package of services and there is a need to contract with the private sector.
Access to services	User fees for services and medicines.	Free at point of services (includes 312 medicines)
	Medicines for priority programs were free. Attending physicians often waived fees for the indigent.	
Per capita expenditure	Varied by state	Varies by state, but it is higher than for people unincorporated to SP who remain uninsured.

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Socioeconomic and health disparities

Variables	National Average and Range (Lowest and Highest Values)
Education index (2002) [44]	0.82 (state range 0.74–0.90)
Income index (2002) [44]	0.74 (state range 0.59–0.90)
Human development index (2004) [45]	0.81 (state range 0.71–0.88) (municipal range 0.38–0.91)
Households with access to water (2005) [3]	94.5% (state range 85.2–98.4)
Life expectancy (2005) [22]	73 y old for men, 77.9 y old for women (There is a 10-y difference in life expectancy between the poorest and richest groups.)
Infant mortality rate (2004) [45]	19.7 per 1,000 live births (state range 14.4–26.3)
Maternal mortality rate (2005) [22]	63.4 per 100,000 live births (state range 9.6–126.7)
Mortality due to infectious diseases (preventable and avoidable if there is timely access to health care) [3]	In poor communities, 25% of deaths for children <5 y of age are due to infectious diseases; in affluent communities, the corresponding figure is 5%.
Health resources	
Per capita expenditure 2005 [22]	US$498 per capita (state range 316–1,103)
Private health care expenditures 2005 (95% out of pocket) [22]	54% of health expenditure is private (state range 28.5%–76.5%). In 2003 [41] health expenditures represented 8.5% of income for lowest income decile and 2.6% for the highest income decile
Public health expenditure as percent of GDP (2006) [3]	2.9% of GDP (state range 2–8.2%)
Physicians per 1,000 population (2005) [22]	1.9 (state range: 1–4)
Beds per 1,000 population (2005) [22]	1.1 (state range: 0.6–2.5)
Nurses per 1,000 population (2005) [22]	2.2 (state range: 1.3–4.6)

GDP, gross domestic product.
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The Mexican Health Financing System

Mexico

After 60 years challenges remain regarding universality, equity and efficiency:

Incremental set up of a Bismarck-type SHI system does not get beyond ≈ 50 % population coverage

Different population groups are benefiting from different benefit packages: more or less comprehensive services

Large population groups are lacking entitlement to health care

Resource-wasting parallel structures mainly of IMSS and SSA ➡ system inefficiencies

The Mexican Health Financing System

Mexico

Segregrated system combining social health insurance (Bismarck), national health service (Beveridge), state-run health insurance, and private sector (market model)

Despite some efforts to create synergies between IMSS and Seguro Popular, the subsector operate widely independent from each other

The Seguro Popular has increased utilisation of health-care services by the informal sector and the poor - but

Risk pools are separated from each other, funds are not integrated

Risk of stigmatisation of beneficiaries

Health system Mexico

Conclusions

- Incremental expansion of social health insurance to the whole population lengthy and cumbersome
- Vested interest are a relevant to be taken into account in health sector reforms
- Covering the informal sector requires particular efforts
- Setting up separate funds for different population groups restricts risk pooling
- Parallel insurance schemes can have negative impact on equity and makes the height and depth of universal coverage more difficult to achieve