Session I: Country experience implementing progressive UHC - Mexico

1. Basic health sector data

- 120 million Mexicans - 79% urban – fertility rate: 2.2
- GDP / capita: 16,500 USD PPP
- U5: 9.2%; >65: 6.7%
- Life expectancy (2013): 74.5 (77 women; 71 men)
- U5MR: 15.7 per 1,000 live births
- MMR: 38.2 per 100k live births

- Mortality: CVD, diabetes, growing problem with diabetes
- Health sector spending: 6.2% of GDP
- 350 USD per capita spending
- 50/50 Public – Private (OOP) financing
- Fragmented health system: 50% social insurance schemes / 50% Seguro Popular

2. Country approach to UHC

- **Before 2004:** various initiatives aimed at expanding coverage managed to cover specific population groups were promoted. Large gaps in financing/access/health conditions. None of these led to UHC.
- **In 2004: Seguro Popular** was introduced for the previously uninsured with a roll-out phased over 7 years. SP meant fresh federal monies to cover an explicit intervention package.
- SP's aim was to close financing gaps:
  1. per capita allocations of federal monies between social insurance and the rest of population (2.5:1)
  2. per capita allocation of federal monies across states (4.3:1)
  3. per capita allocation of complementary state –level funding (115:1)
  4. family based contributions based on socioeconomic level

Session I: Country experience implementing progressive UHC - Mexico

3. After 11 years of Seguro Popular …

- All the population have right to access to publicly financed health insurance (social security, Seguro Popular, etc.) = 100% "administrative" coverage
- Public funding for the population who didn't 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 reduced: from 2.5:1 to 1.6:1 (between 2004 and 2013).
- Yet, not everybody has "effective access" and there is large heterogeneity in the interventions covered and quality of care across publicly-funded insurance schemes.
- Disparities intrinsic to the fragmented structure of the health system haven't been fully tackled.
- Given the obstacles to undertake a major structural reform, the option seems to continue promoting small changes, in order to eventually converge to the same basic standards of care coverage and delivery, technical efficiency and quality of care.

4. Most important lessons

1. Do not forget community-based public health interventions.
2. Do not under-estimate slow supply-side response, especially human resources for health.
3. Implementing reform in a decentralized context requires additional efforts to strengthen response capacity, especially if there is large heterogeneity in managerial capacities at the state level.
4. Strong stewardship (A): Need for strong monitoring of progress and capacity building to evaluate impact (health gains and financial protection).
5. Strong stewardship (B): Quality assurance (more monies deliver more clinical activity with uncertain outcomes).

1. **How can leaders of the MoH and UHC reformers and advocates can best generate and sustain political will?**

   a. Win the legal/ethical argument - Use the constitutional /legal mandate for "the right to health". Fair health financing as part of fiscal equity principles

   b. Gain MoF support – counter fear for use of "entitlements" and "earmarking" in social spending + use efficiency gains and resource optimization as an argument in favor of UHC

   c. Work the political base
      - Mobilize subnational governments
      - Population groups likely to win
      - Avoid ownership along party lines

2. How can countries successfully address political challenges and manage opposition to UHC implementation?

Source of challenges & opposition	Critic's claims	How to face challenge or counter opposition
a. MoF	Value for money (mismanagement / corruption /wastage, especially in decentralized settings)	Build external monitoring capacity / centralize payments
b. Trade unions / contributors to social insurance	Sustained gaps in access (especially rural communities)	Evaluate and publish impact results (by independent third party if possible)
c. Social security institutions	Health insurance promotes informality	Get the academic community involved in answering policy impact questions
d. Political parties that claim electoral motives	Electoral use of UHC programs	Avoid political appointments in key posts
e. NGOs and media	Lack of transparency / access and quality concerns	Work on demand and supply barriers
f. Private /non-government providers	Outsourcing care is more efficient	Pilot strategic private provision
g. Local governments & health workers	Reforms tend to increase workload with no extra benefits or jobs being cut	Work with local governments and health workers to dissipate fear and explain reforms