Mexico:
Governing for Quality Improvement in the Context of UHC

Background

History: A pilot study was conducted in 2001 to explore the feasibility of implementing a public health insurance for those not covered by social security. In 2004, Mexico scaled-up this complementary tax-based public health insurance scheme, System of Social Protection in Health (SSPH), after a law was approved by Congress in 2003. This law was based on the Constitutional reform of every citizen's right to health protection (est. in 1983). This national health insurance programme also called *Seguro Popular*, is providing access to a package of comprehensive health services with financial protection for more than 50 million Mexicans previously excluded from public, social insurance. While Mexico has made strong progress in coverage over the last decade, Mexico still experiences fragmentation and ineffective access as a result.

Governance: The scheme is administered and stewarded by the Ministry of Health (MOH). Mexico's health system is guided by the federal government but operations are decentralized to the state level. Family premiums as well as federal transfers are collected at the state level. The states are also responsible for the provision of health services. The function of the Social Protection in Health Regimes (REPSS) at the state level is to integrate and coordinate the network of health care providers in order to guarantee that SP enrollees have access to the services offered under the benefits package. The mechanisms used to control the network of providers are subscription agreements and contracts with public, private, and civil society institutions.

Background Country Data	
Total Population	119.5 million
OOP health expenditure (% of total expenditure)	45 %
Life Expectancy at birth (years, both sexes)	74.7 years
Infant Mortality (per 1,000 births)	13
Maternal Mortality (per 100,000 births)	38.2
Hospital beds (per 1,000 people)	1.6
Public health expenditure (% of total health expenditure)	51%
Total health expenditure (% GDP)	3.2 %

Source: National Institute of Statistic and Geography, 2015; OECD's second Health System Review of Mexico, 2016.

Financing: Approximately half of health spending in Mexico (~6.5% of GDP) is private, primarily from out-of-pocket expenditure. The SP is financed by the federal government, the state government, and enrollees and complements the existing employment-based social insurance mechanisms limited to salaried workers. Federal and state governments fund a social solidarity contribution while enrolled families contribute a premium that is tied to income, yet for low-income families this source of financing is insignificant. The separation of funding between personal health services and health-related public goods (including non-personal health services) is designed to protect public health services, which tend to be at risk in reforms that expand insurance. Funding for personal or clinical services, by contrast, is based on a public insurance logic focusing on risk pooling, prepaid contributions according to capacity to pay, progressive subsidies provided through public funding from general taxation, and explicit entitlement to a package of health interventions.

Quality: In 1987 in Mexico the "Basis for the evaluation of the quality of care in the medical units of the health sector" were developed by the MOH to assess the quality of care in the medical units. In the period 2001-2006, the MOH initiated a reform in quality of care, including the "National Crusade for Quality of Health Services", the first nationwide strategy for quality in Mexico. In 2003, as part of a reform of the General Health Law, accreditation of health care units providing services under

Seguro Popular was mandated. In the period 2007-2012, the "National Crusade for Quality of Health Services" migrated to the Integral Quality System in Health (SICALIDAD).

The actual quality strategy is called "National Strategy for Strengthening Quality in Establishments and Health Services." It contributes to raising quality through the provision of safe and effective services for the population within institutions of the National Health System, and is based on six components:

1. Quality and patient safety
2. Innovation and continuous improvement
3. Risk management in health care
4. Accreditation of health care facilities and health services
5. Regulations on health
6. Health education

Currently the MOH, through the General Direction for Quality of Health Care and Education, has within its functions to dictate the policy of quality health care for the country. It aims to achieve: population health, reliable and secure organizations, reasonable costs, effective access, and satisfactory experience for the population

Key Lessons on Sequencing of Quality Reforms

- ***Success:*** Quality has improved through the accreditation process in some health care units. This mechanism needs to be improved to achieve the established quality standards to all units financed by Seguro Popular.
- ***Challenge:*** A new health care model is being designed to strengthen primary care, as well as improve the continuity of care. Quality is still an issue that needs to be comprehensively addressed not only in health care units financed by Seguro Popular, but also in Social Security units.
- ***Lessons learned:*** Given that affiliation and financing were given top priority when Seguro Popular was implemented, ensuring effective quality health care was neglected. Quality health care provision should have been developed simultaneously to affiliation and financing processes. Furthermore, some of the Seguro Popular resources should have been allocated based on some kind of performance standards.
- ***Approaches, solutions, and strategies:*** Accreditation is the principle approach used to strengthen quality of care for Seguro Popular. Currently, the Ministry of Health is designing a new federal agency to regulate and monitor quality of health care across the whole system.
- ***An example of a "success":*** In 2014, a reduction of 42.3 % was observed regarding the mortality rate for cervical cancer registered in 2000. In recent years it has maintained a downward trend in the indicator of infant mortality; by 2014, it was 12.7 per thousand live births. Increase in life expectancy; in 2013, life expectancy at birth in Mexico was 72.2 years for males and 78.7 years for females.
- ***An example of a "lesson learned":*** It is necessary to strengthen primary health care; poor monitoring and evaluation of public service past reforms have been identified as impediment to a more sustained program of reform.
- ***Key challenges:***
  - Quality of primary health care: Admissions for uncontrolled diabetes are nearly the highest in the OECD; this indicator suggests that the care provided for diabetes outside of hospitals is weak. Indicators of the quality of acute care also show cause for concern in Mexico. Admission-based case-fatality in adults aged 45 and over within 30 days after admission for acute myocardial infarction (AMI, or heart attack) was 28.2 deaths per 100 admissions in Mexico in 2013, compared to the OECD average (excluding Mexico) of 7.4. Mortality in hospital following a stroke (case-fatality in adults aged 45 and over within 30 days after admission for ischemic stroke) was also higher in Mexico than in any other OECD country, at 19.5 deaths per 100 admissions compared to an average (excluding Mexico) of 8.0 across the OECD.
  - Information, monitoring and evaluation: Most of existing data work in Mexico focuses on acute hospital care for the public sector (no information about private establishments). Mexico also has very few national patient registers to monitor the quality and outcomes of care. Information on quality of care limited. The same applies to internationally comparable indicators of quality, where Mexico was able to report on only 8 out of 52 requested OECD Health Care Quality Indicators in 2015. Measures of activity and outcomes in primary care and preventive care are lacking. Systematic use of information systems to improve care appears rare.
  - Regulation of establishments: Currently, accreditation is only mandatory for the providers of services to *Seguro Popular*.

Overview of Governing Quality – Key Inputs and Processes

Function of Quality	Institution Responsible for Function	Key Features and Processes
Regulation	• Ministry of Health (MOH), through the General Direction for Quality of Health Care and Education (DGCES).	• DGCES has within its functions the Accreditation of health care facilities that provide services to the Seguro Popular. • Currently, the MOH is designing a new federal agency to regulate and monitor quality of health care across the whole system.
Law and Policies	• Ministry of Health (MOH), through the General Direction for Quality of Health Care and Education (DGCES).	• The General Health Law regulates the right to the protection of the health of any person in terms of the 4th article of the Constitution of the United Mexican States; it establishes the bases and modalities for access to health services, and the participation of the Federation and states in matters of public health. It applies throughout the Republic and its provisions are from public order and social interest. • DGCES has within its functions to dictate the policy of quality health care for the country.
Leadership and Management	• Ministry of Health (MOH), through the General Direction for Quality of Health Care and Education (DGCES).	• DGCES dictate the policy of quality health care, and the states implement it. Each state has a person in charge of quality issues, aligned to the national strategy. Also, every health unit has a quality office. • The actual strategy in terms of quality is called "National Strategy for Strengthening Quality in Establishments and Health Services", it contributes to raise the quality, through the provision of safe and effective services for the population, in institutions of the National Health System.
Monitoring and Evaluation	• Ministry of Health (MOH), through the General Direction for Quality of Health Care and Education (DGCES). • The National Commission for Medical Arbitration (CONAMED)	• DGCES has developed the National System of Health Quality Indicators (INDICAS); it is a tool for recording and monitoring quality indicators in the units of health services, it also allows to make comparisons between health care units in the country. Information is self-reported, so its information is not completely reliable. Actually DGCES is developing a project with NICE International, to strengthen the existing monitoring system, taking into account international experience in the design and implementation of quality indicators. • CONAMED resolves conflicts arising between patients and providers. (Lopez et al., 2015) The National Healthcare Quality Campaign introduced a process for submitting complaints and suggestions on how to improve services. (Frenk et al., 2006) • User perceptions of quality are measured every six years in the National Health Surveys. (Lopez et al., 2015) • Currently, the MOH is designing a new federal agency to regulate and monitor quality of health care across the whole system.
Planning	• Ministry of Health (MOH), through the General Direction for Quality of Health Care and Education (DGCES).	• Every year, DGCES develops an accreditation calendar, in order to supervise units that require to be accredited or re-accredited.
Financing	• System of Social Protection in Health (Seguro Popular): public health insurance for those not covered by social security	• Facilities that provide services to *Seguro Popular* must be accredited in order to participate in the insurance scheme. (Lopez et al., 2015)

Sources

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