Commentary

Financing Common Goods: The Mexican System for Social Protection in Health Agenda

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A series of studies developed in Mexico in the late 1990s identified disturbing rates of catastrophic health expenditures as a result of the fact that approximately half of the Mexican population, 50 million people, lacked health insurance.¹ This analysis exposed a dreadful paradox: we know that health contributes to the reduction of poverty, yet medical care can itself produce financial stress when a country lacks the social instruments to assure fair financing of personal healthcare services.

In 2003, the government of President Vicente Fox secured support from all political parties for legislation aimed at correcting that paradox. A reform to the National Health Law created the System for Social Protection in Health (SSPH).² The most prominent component of SSPH is Seguro Popular (SP), a health insurance scheme funded predominantly through federal and state subsidies.

Following congressional approval of SP, the government began implementation of the new system in January of 2004. Public expenditure was gradually expanded to finance healthcare coverage for non-salaried workers and their families, who had been excluded from conventional, employment-based social insurance. The mobilization of additional financial resources for health was made possible by the increase of oil prices between 1999 and 2008, a situation that benefited Mexico, an oil-exporter country. This allowed for a major increase of social expenditure. By 2018, over 53 million people were enrolled in the new scheme and had access to a comprehensive package of essential services and a package of high-cost interventions.³ The country was on track to achieving the goal of universal coverage.

A lot has been written about SP, its financial innovations, and its impacts on healthcare coverage, health conditions, and financial protection.⁴⁻¹¹ However, little is published about the other components of SSPH, more specifically, its common goods components. The purpose of this article is to describe and discuss the common goods for health elements.
of Mexico’s SSPH: stewardship and community health services. Its main conclusion is that in order to expand coverage, improve health conditions and guarantee financial protection, UHC strategies need to strengthen not only the financing and delivery of personal health services but also the stewardship function of health systems and the delivery of community or public health services.\textsuperscript{12}

**CONCEPTUAL FRAMEWORK OF THE MEXICAN HEALTH REFORM**

The Mexican health reform was designed using as reference the 2000 WHO framework for the assessment of health systems performance, which identifies three intrinsic goals and four basic functions of health systems, along with a health goods classification with two main categories: health-related common goods and personal health services.\textsuperscript{13-15}

In the classical economics formulation, a health-related common good is defined by two features: a person can consume it without reducing its availability to others (non-rivalrous) and no one is deprived of its consumption (non-excludable).\textsuperscript{16} Examples of this type of good are sanitary regulation, health information, evaluation, knowledge from health research, and community health services, such as epidemiological surveillance, environmental services, and disaster preparedness and response. There are some services, such as vaccines, that are rivalrous but that in this framework are considered common goods because they produce positive social externalities (reduce the risk of infection). In the Mexican reform, financing of common goods related to health followed a conventional budget logic based on general taxes, since these goods benefit all groups, regardless of their affiliation to a specific healthcare institution.

Personal health services (preventive, diagnostic, curative, palliative, and rehabilitation services) are those provided to individuals who demand them in health facilities. Given the uncertainty implicit in the loss of health, financing of this type of service was based on a public insurance logic, which assures protection against catastrophic health expenditure.

A fundamental principle of the reform was that effective provision of universal and comprehensive personal health services and health-related common goods would guarantee social protection in health, which includes three types of security. The first is ‘financial security,’ which refers to protection against the economic consequences of disease, especially against the risk of catastrophic or impoverishing expenditures that result from paying for care. The second dimension is ‘healthcare security,’ related to safety from iatrogenic harm, effectiveness and, very importantly, responsiveness that safeguards the dignity of patients. And third, what could be called ‘epidemiological security,’ which refers to the protection against specific risks of disease or injury through biological and chemical agents.

SSPH was designed to provide both types of services and the three types of security, with SP focused mostly on healthcare and financial security, and a common good component providing mostly epidemiological security (Figure 1).

**FINANCIAL ARCHITECTURE OF THE SYSTEM FOR SOCIAL PROTECTION IN HEALTH**

The common goods component offered by SSPH includes two subtypes of services: first, community health services,

| Type of health good | Health good | Financing fund |
|---------------------|-------------|----------------|
| Common goods related to health | • Stewardship  
• Information, evaluation, research | Regular budget of the Ministry of Health |
| Community health services (epidemiologic surveillance, environmental services, community services, disaster preparedness and response) | | Fund for Community Health Services |
| Personal health services (Seguro Popular) | Essential healthcare services (primary and secondary care) | Fund for Personal Health Services |
| | Highly specialized tertiary care services associated with catastrophic expenditure | Fund for Protection against Catastrophic Expenditure |

**FIGURE 1.** Relation between Types of Goods and Financing Funds in the System for Social Protection in Health of Mexico Source: Refs. 4, 15
which are financed with resources from a separate fund established for this specific purpose in the law; second, stewardship and other activities, financed through the regular budget of the Ministry of Health (MoH). The personal health services component is represented by SP, which guarantees to those enrolled in it access to a package of essential services, financed with resources from the Fund for Personal Health Services, and a package of high-cost interventions, financed with resources from the Fund for the Protection against Catastrophic Expenditure.

The rationale behind this architecture was to separate funding of health-related common goods from funding of personal health services in order to protect the former from being under-financed or even neglected during a reform process that was centered around demand-driven healthcare financing. Enrolment to SP was implemented over more than 10 years to reach, as mentioned before, 53 million enrollees in 2015. The number of covered interventions was also expanded gradually, as resources increased with the number of enrolled individuals, to reach 290 essential services and 65 high-cost interventions in that same year.

The strengthening of health-related common goods started before the implementation of SSPH but resources to finance them increased with its formal creation. They included public health activities and several stewardship sub-functions (regulation, information, evaluation, and health research promotion), which will be discussed in the following section.

HEALTH-RELATED COMMON GOODS OF THE SSPH

Community Health Services

The creation of a Fund for Community Health Services targeting health promotion and disease prevention allowed, among other things, for a major expansion of the national immunization program and additional investments to enhance security through improved epidemiological surveillance and preparedness.

Since the 1990s, Mexico has developed a strong national immunization program. However, additional improvements were reached at the turn of the century thanks to SSPH. By 2006 children in Mexico had free access to one of the broadest immunization schemes in the world, which includes vaccines against hepatitis B, diphtheria, tetanus, pertussis, Haemophilus influenzae type b, polio, measles, mumps, rubella, influenza, TB, and meningitis. Complete immunization coverages in children under 1 and under 5 that same year were over 95%, one of the highest immunization coverages in the Americas. Recently, the vaccine against HPV was added to this scheme, and there is now free and universal access to this intervention.

Additional public health investments have been made to enhance human security through stronger epidemiological surveillance and preparedness to respond to emergencies, natural disasters, and many of the threats related to globalization, including potential pandemics. These investments included the strengthening of the strategic stockpile of medical supplies for public health emergencies and the upgrading of the network of public health laboratories, one for each of the 32 states in the country. This surveillance, preparedness and response system was successfully tested during the H1N1 influenza pandemic in 2009.

Regulation

Regarding stewardship (which includes system design, performance assessment, priority setting, intersectoral advocacy, regulation, and consumer protection), probably the most important innovation associated to SSPH was the establishment of a new public health agency, the National Commission for Health Risk Protection [Comisión Nacional de Protección contra Riesgos Sanitarios (COFEPRIS)], which is responsible for food safety, definition of environmental standards, promotion of occupational safety and prevention of work-related injury, regulation of the pharmaceutical industry, and control of hazardous substances like alcohol, tobacco, and sugar-sweetened beverages (SSBs). This agency has played a crucial role in the design and implementation of policies to combat tobacco consumption, which include cigarette-excise taxes, health warnings, smoke-free air laws, and marketing restrictions. Thanks to these measures Mexico was one of the four countries in the world that was able to reduce smoking prevalence in the population aged 15 years or older by half between 1980 and 2012. COFEPRIS has also played an important role in the successful implementation of SSBs taxes in Mexico.

Health Information

Before the reform, the MoH had a strong unit in charge of the collection, generation, and dissemination of information on health needs, resources, and services. However, major efforts were made to strengthen it in order to generate solid and comprehensive information that could feed the planning, operation, and evaluation process. Thanks to these and other more recent efforts, this unit is now staffed with highly trained technical specialists capable of generating timely
and high-quality information through the implementation of censuses, surveys, and routine information processes, using state-of-the-art procedures and methodologies.\textsuperscript{23}

**Evaluation**

Another innovation associated to SSPH was the creation of a comprehensive evaluation system with three components: i) monitoring of personal and public health services; ii) program evaluation; and iii) health system performance assessment.\textsuperscript{24} The assumption behind this framework was that the first component would be useful mostly for management, the third mostly for policy, and the second for both, bearing in mind that all three components would be crucial for accountability purposes.

Through the program evaluation component, an external evaluation of SP using an experimental design was implemented.\textsuperscript{10} This evaluation is considered “one of the largest randomized health-policy experiments ever.”\textsuperscript{25} Its main finding was a reduction in catastrophic expenditures attributable to SP.

**Research Promotion**

The Mexican reform benefited from and promoted health research. The design of the reform was nurtured by knowledge-related public goods that were generated in national and global academic centers and multilateral institutions. Conscious of the importance of health research, Mexican health authorities strengthened during the reform process the relationship with these institutions. Researchers from these centers produced relevant policy analyses, carried out independent and credible evaluations, and greatly enriched the quality of information.

**CONCLUSIONS**

In order to expand coverage, improve health conditions, and guarantee financial security, UHC strategies must reinforce the delivery and financing of personal health services, but they also need to strengthen the stewardship function of health systems and the delivery of public health services. Sanitary regulation, surveillance, and preparedness are crucial for epidemiological security, which contributes to the improvement of health conditions, while information, research, and evaluation generate inputs that influence the whole health system and therefore contribute to the expansion of coverage, as well as healthcare and financial security.

The Mexican health reform, in addition to expanding coverage of personal health services, was able to strengthen the stewardship function of the health system, mostly at the national level, and provide a wide array of health-related common goods, which are coordinated by the national MoH but delivered as a state responsibility. Most of the stewardship instruments (COFEPRIS, health information, research promotion) and public health systems (surveillance and preparedness systems) that were strengthened or created through SSPH remain in place, but one of them (evaluation system) has practically disappeared due to the lack of interest for evaluation procedures and declining commitment to accountability by recent administrations. This leads to a final conclusion: in order to produce positive, sustainable changes, UHC strategies require the institutionalization of successful policy initiatives and continuous efforts to support reform initiatives over long periods of time.

**DISCLOSURE OF POTENTIAL CONFLICTS OF INTEREST**

No potential conflicts of interest were disclosed.

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