A CASE STUDY OF THE FEDERAL HEALTH SYSTEM IN MEXICO

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CONTENTS

ACRONYMS

PRI (Institutional Revolutionary Party)

PAN (National Action Party)

PRD (Democratic Revolution Party)

PNR (National Revolutionary Party)

CSS (Coordination of Health Services Office)

COPLADE (Committees for State Development Planning)

SSA (Secretariat of Sanitation and Assistance or Ministry of Health)

IMSS (Mexican Institute of Social Security)

IMSS-COPRALMAR (Health services for uninsured population)

IMSS-SOLIDARIDAD (Health services for the poorest uninsured population)

PIB (Gross national product)

ISSSTE (Institute of Social Security and Services for State Workers)

CONASUPO (National Council of Popular Subsistence)

SIDA (Acquired Immunodeficiency Syndrome)

ECV (Cardiovascular Diseases)

AVIS (Healthy Life Years)

IM (Marginality Index)

ICVM (Funds of Disability, Old age, Retirement, and Death)

SNCF (National System of Fiscal Coordination)

IVA (Aggregate Value Tax)

FGP (General Sharing Fund)

FFC (Complementary Financial Fund)

FFM (Fund for Municipal Promotion)

LCF (Law of Fiscal Coordination)

FUNSALUD (Mexican Health Foundation)

MIDAS (Integrated Health Care Model)

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EXECUTIVE SUMMARY

The Mexican Health System began, developed, and was consolidated within a federal system that posits a balance of the legislative, executive, and judiciary powers in theory, although this balance is not achieved in practice. Indeed, power and thus decision making are vertically distributed, with excessive governmental centralization of power, particularly in the president and close collaborators. In this context, the official health policy in the last 30 years has aimed at decentralizing power while retaining central control.

The underlying purpose of the decentralization policy in Mexico is to centralize by decentralizing. Health policies in Mexico have always been based on municipal actions led by the Consejo Superior de Salubridad (Higher Council of Hygiene), and have been clearly insufficient. It was necessary to create a Federal Executive government agency with enough power to allocate resources and establish regulations for epidemic control and urban sanitation.

After that, three political strategies for allocating public resources were defined, as follows: resources for the uninsured population, resources for insured state workers, and resources for insured, formal economy workers.

The foundation of the present health system is related to the aforementioned strategies and can be traced to 1943, the year when the two main components of the Mexican Health System were established: Instituto Mexicano del Seguro Social (IMSS) (Mexican Institute of Social Security) and Secretaría de Salubridad y Asistencia (SSA) (Secretariat of Sanitation and Assistance, recently called Secretariat of Health).

The IMSS was created to collect tripartite contributions (from government, employers, and workers), as a means of favoring industrialization in the main urban areas. All this under government direction, and public offers to assist total medical services strategically aimed to help economic development.

The main objective of the SSA was to assign resources to Servicios Coordinados de Salud Pública. Health care provision was extended to cover in a more comprehensive way the population deprived by Social Security, including the majority of peasants, the unemployed, and informal economy workers.

The third significant development was the creation of Instituto de Seguridad y Servicios Sociales para los Trabajadores del Estado (ISSSTE) which consolidated the diversity of pension and fringe benefit systems for state workers.

Even though there are notable underachievements in the health conditions of the population and underoptimal developments of the health system, it is possible to show the accomplishments effectiveness, by analyzing some empirical evidence through health indicators. Indeed, by comparing 1940 vs. 1998 indicators, general mortality decreased from 23/1000 to 4/1000 inhabitants; child mortality from 158 to 28; and maternal mortality from 53 to 6.

Variations in these and other indicators allow for the regionalization of the 32 Mexican states into five different regions with distinct epidemiologic patterns, showing important differences

regarding the burden of disease and financial requirements. By taking this into account, political actors related to the health system (providers, political parties, users, employers, and governments), strive to reach consensus on how to design and implement new political strategies towards greater equity, efficiency, access, quality, and effectiveness of the health system. These strategies have been the subject of discussion in the past 30 years, and may be summarized along five categories: extension of coverage, municipal participation, implementation of a basic health package, reorganization of health care services, and, more recently, the creation of a national health system.

INTRODUCTION

This document presents an analysis of the Mexican Federal Health System. To place the health system in the context of the "New Federalism", the first section includes a review of the main characteristics, determinants, and current status of federalism in Mexico. Emphasis is made on the high concentration of power at the central government level; substantial change in the federal power structure has occurred in recent years, and particularly in 2000, resulting in an apparent balance and autonomy between the legislative and executive powers. Despite these changes, the Mexican political system is still dominated by the president and closest aides. The analysis of relationships among the various governmental levels provides a detailed description of the constitutional power distribution within the Mexican political system.

The second section presents a somewhat detailed analysis of the political and legal framework that advances and intends to implement the federalization of health in Mexico as the most effective strategy to improve health care in the 32 states of the country. This section also describes the origins, accomplishments, and current status of the Mexican health system as well as the challenges to health care programs and policies. Emphasis is made on the shaping of the health care system as a result of political and labor forces, as well as to social economic, demographic and epidemiologic change, from its early development in the 30s and 40s to the beginning of 2001.

To identify potential contributions of the health care system to the health conditions of the population, a brief descriptive analysis of selected health indicators over the past 50 years is presented as a measure of effectiveness. Finally, the author discusses the current burden of disease and resulting health priorities, analyzing the health effects by region.

The third section includes a descriptive analysis of the main changes and trends of health policies, programs, and strategies occurring since the 80s up to the recent health care reform proposal officially presented in July 2001. Emphasis is made on the political dimension and the main political actors that shape and define the current health system in Mexico. The fourth section presents an analysis of the main changes, effectiveness, and likely trends of health service production policies for uninsured and insured populations.

The fifth section includes an analysis of changes and trends in health financing, presenting with some detail the financing mechanisms at the federal, state, and municipal levels. This section ends by analyzing the effectiveness of financing policy changes from original research findings in a study that analyzed four Mexican states. Finally the Discussion and Conclusions section suggests and recommends lines of research and action to advance the Mexican Health System in the context of the New Federalism and the main political strategies of the National Health Program 2001-2006.

1. FEDERALISM IN MEXICO

The Mexican political system is officially acknowledged as being a federal system, having a fairly equitable distribution of power among the main political actors and settings. The Mexican political Constitution establishes the power structure of the Mexican government in three autonomous branches -- executive, legislative, and judiciary powers -- functioning within a federal system that imparts autonomy to states. The theoretical balance of powers does not occur in practice. Instead, power is concentrated in the office of the President and his closest aides through a set of institutional structures, including the Partido Revolucionario Institucional (PRI), the official ruling party throughout the second half of the 20th century; and Partido Acción Nacional (PAN), the ruling party starting in 2000. In this document, the distinctive characteristics of the Mexican political system are described in detail to show the types of intergovernmental relations and power structures on which the Mexican Health System arises, evolves, and is reformed in the context of a federal system.

1.1. Distinctive characteristics of Mexican federalism, distribution of power and intergovernmental relations

Decision making in Mexico is very centralized, and the executive power has an almost unrestrained authority over legislative and judiciary powers, as well as over any other political actor. Only until recently have both Houses of Congress ceased to be overwhelmingly dominated by members of the PRI. Opposition party members used to take it for granted that their opinions would not influence legislation, but the fall of PRI in 2000 has given way to a better balance among political parties (PRI, PAN, and PRD). Despite these recent changes, the ways of the old political culture persist, epitomized by a dominance of the Presidential figure, and it extends to the lower levels of government. Consequently, state and municipal governments have become dependent on centralist, federal government initiatives. This situation places the municipal government at the bottom of the federal-state-local government pyramid concerning public policy decision-making and intergovernmental relations.

As a result, despite official discourse, federalism in Mexico is severely restrained. Over 50 years ago, some authors declared that federalism never actually existed in Mexico. Mexico has been a federal system only in theory; in practice, centralism is the main form of government. After the 1910 revolution, a new political system was established, but then again, it became dominated by the central model of government. The new government took over control of local government slowly but surely. To support local governments, a few institutions were created, among which the most important was the Partido Nacional Revolucionario. This party was created in 1929, later becoming Partido Revolucionario Institucional, which took over control of federal ruling power until 2000. It should be noted that some authors consider that the PRI's main course of action was to wield power from the central level without sharing it with the states and municipalities.

Distribution of power in Mexico is centralized by the political system, even though precedence should be granted to states and municipalities (the Free Municipality, according to the Political Constitution). In practice, power is centralized mainly by the Executive arm of government. The Mexican President is empowered to act as a constitutional power,

invested with the authority to amend the constitution. He can also act as the chief legislator, set himself as the ultimate authority in electoral issues, claim jurisdiction, and dismiss governors, municipality mayors, and federal or state congress persons. This combination of constitutional and metaconstitutional powers make the Mexican President one of the most powerful commanders-in-chief of any democracy. The high degree of centralization, concentrated in the hands of the President, substantially diminishes the ability of separate powers to function as a system of checks and balances.

Intergovernmental relations have been determined for the most part, by the highly centralized nature of the Mexican political system for the past 60 years. They have become stable, like the system itself, despite the change of ruling party. Since the system's centralization served as one of the most influential forces for its stability, change in intergovernmental relations can hardly be expected.

The study of the relationship between central and local governments, although it has been neglected for some time, is considered decisive for the democratization process and for the effectiveness of public policies. The relationship between democracy and local autonomy has acquired new strength in countries with incipient democracies. In Mexico, decentralization efforts during the last decade have attempted to change intergovernmental relations. On the other hand, "who's in charge" is of special interest since the structure of power is inevitably reflected in the policies, and determines who benefits from public policy.

1.2. The decentralization policy: towards a change in power structure and new intergovernmental relations.

Although the Political Constitution outlines that local governments are to be autonomous, it does not specifically state how this autonomy is to be put into operation. Thus, the fundamental objective of changing the roles of the local and state governments is to achieve the degree of autonomy that has been recouped by Mexico City. Most would agree that very little has actually been gained, and that the states are still controlled by the central government while the municipalities are controlled by the state governments. In this sense, the municipal government's dependency on the federal and state government levels has always been directly related to economic dependency. Formerly, municipalities were unable to charge taxes on property or salaries.

Thus, all taxes were paid to the federal and state governments. Little money would be left for local projects, and municipal governments were driven to seek other income sources, such as vendor-market, slaughterhouse, or commercial establishments' license payments. Municipal governments became more dependent when the federal government assumed the responsibility of providing basic public services, such as housing, schools, clinics, hospitals, and health programs for every community. All these matters depended, and may still depend, on some representative in the central government.

In this context, during the last 25 years, the decentralization process has been one of the driving forces of Mexican politics. The 1983 municipal reform is a turning point because it not only lays the foundation for subsequent decentralization programs, but it also started the

development of a "decentralization culture" in Mexico. In the early 80s an initiative was introduced to reform article 115 of the Constitution, which refers to the coordination of municipal governments. Basically, the purpose of this suggested reform was to guarantee permanent, committed income sources. This would allow municipalities to provide public services and, more importantly, to strengthen their political and to some extent economic independence. Public administration, public services (particularly health and education), financial control, and development planning were the aspects most directly affected by the growing municipal government autonomy. Politically, the reform sought to render the municipal governments more pluralistic. Regarding administration, municipalities were allowed to set their own internal governance rules.

From the early 80s through the late 90s the Mexican government took up an extensive decentralization program as a means of maintaining political power and strengthening its shaky legitimacy. The principle of decentralization seemed particularly prominent during the 90s. In fact, a genuine decentralization became unavoidable for the ruling party (PRI) if it was to survive and stay in control of the central government.

This apparent paradox -- relinquishing power in order to keep it, or at least pretending that it was being relinquished -- illustrates the governmental distribution of power in Mexico today. To centralize by decentralizing: this was (and somehow still is) the underlying purpose of the decentralization policy in Mexico. Mexican federalism, the power structure, and the decentralization strategy have greatly affected the organized response to satisfy the population's health needs, particularly the health system's federalization project. These effects are discussed further in the next section.

2. THE ORGANIZED SOCIAL RESPONSE AND THE CHALLENGES TO THE MEXICAN HEALTH SYSTEM.

2.1. Origin and evolution of the Mexican health system's programs and policies.

Since their inception, health policies in Mexico have been based on municipal actions oriented by the Consejo Superior de Salubridad (Higher Council for Sanitation), and have proved clearly deficient. An office of the Federal Executive had to be created with sufficient power to allocate resources and regulate activities against epidemics, and to improve urban sanitation. The Departamento de Salubridad was created, supported by Consejo de Salubridad General, which served, along with legislative agencies, as the advisory and managing bodies to issue specific health interventions. Until 1929 this policy allowed for the implementation of Cooperative Units with states and municipalities.

When the great depression reduced federal income and imperiled the government's stability, the Cooperative Sanitation Units model seemed insufficient. A large government investment was sought for the reactivation of the economy, which led to goal setting in sanitation at a national level. For this effect, the Coordinated Public Health Services were established to facilitate collaboration between the federal and state governments. During the 30s, the policies that had been set during the revolutionary period were still followed. In addition, a new medical care model was created: conjoint health services among the government, agricultural development banks, and peasants endowed with vast land extensions. Under this

new policy, the Sanitation Department worked to start and maintain intensive care in curative care referrals. The new health policy became quite dynamic on account of government support (which was quickly acknowledged) of production through personal health services for workers.

In the 40s the coexistence of the three main public health resource allocation bodies became apparent. To this day, they are still active. They are: 1) Resources (procured through campaigning by the Cooperative Sanitation Units) for highly specific health problems. 2) Resource allocation for non-personal services; less significantly, aid for all state and municipality residents as intended by Coordinated Public Health Services (CCS) in the states. 3) Public and private resource allocation for personal health services for strategic productive groups through contributions from workers, capital partners, and the government. These three general guidelines had substantial economic influence; thus, they were central to the conformation of the present health system.

The foundation of the health system can be traced to as early as 1943, the year in which the IMSS and the SSA were established to convey tripartite contributions (state, business and workers' funds) for supporting the industrial development of the main cities. This model prevailed almost worldwide; its technical core was drawn from the International Labour Organization. At the same time, its main lines of action suited the needs of the country, given the scarce supply of private services and the government's reliance on its ability to provide comprehensive health services and target them at supporting economic growth.

The SSA arose from the fusion of the Secretaria de Asistencia and Departamento de Salubridad. Its objective was to allocate resources to Servicios Coordinados de Salud Publica. Its health care mission was extended to provide more comprehensive care for the population left unprotected by social security, which included the majority of peasants, the unemployed, and informal economy workers. The SSA was also in charge of launching massive campaigns to control epidemics and specific health problems. An additional advancement of this period was the creation of the ISSSTE in 1959, which consolidated the diversity of pension and fringe benefit systems for state workers.

In the 60s, the GNP grew at average rates of over six percent annually; this growth allowed the IMSS to double its coverage in the second half of the decade. The swift growth of Mexico's middle class gave way to a greater supply of private services. Also, the SSA extended and regionalized its health services, in both urban and rural areas. After that, the decade of the 70s saw a significant overlapping of official responsibilities related to social security and health services. Coverage of low-income populations by the IMSS, SSA, and other state and local health services exposed the difficulties involved in the coordination and regulation of institutions characterized by their centralism and deep-rooted autonomy. To address this problem, in 1983 early efforts were made to launch the federalization process of the Mexican Health System, mainly the reform initiatives recently advanced.

2.2. The federalization of health in Mexico: proposal, instrumentation, phases, and advancements in the decentralization of health services

Given that decentralization was a guide for the policies of Mexican states, the CCS established that centralism had reduced the ability of the Coordinated Services to guarantee the right to health. Local authorities took no part in planning infrastructure development and implementing priority programs. They were unable to efficiently and effectively access institutional resources. Also, the COPLADE, institutions for the decentralization of federal investment decisions, emphasized federal rather than local realities.

In the framework of the national and state health policies of the last two decades, decentralization was a guiding principle for the government to fight off centralism and reorient social welfare productive activities, according to the National Development Plan for that period. An in-depth health reform was undertaken based on the decentralization of health services during the 80s. Its main points were: the upgrading of the right to the protection of health to constitutional status (article IV of the Mexican Constitution and Ley General de Salud), the enactment and organization of the National Health System, and the introduction of preventive care as the central policy in health programs.

The decentralization of health services was envisioned as a political, legal, and administrative process involving the devolution of faculties, programs, and resources from the federation to the local governments. This was to be accomplished through the distribution of responsibilities, the coordination of health programs at the local level, and the provision of health services to the population at large under the responsibility of state authorities. The objective was to extend coverage and improve the quality and efficiency of the provision of health services under the leadership of local authorities. This would further the federalism process, facilitate the establishment of the National Health System, and encourage the participation of the social and private sectors.

This process involved reforming local Constitutions and issuing State Health Laws. In addition, several decrees were issued to regulate process times and types. Moreover, the federation, states, and municipalities convened agreements and devised coordination instruments through conventional ways, as well as through the Convenio Unico de Desarrollo (Sole Agreement for Development).

Decentralization was instituted gradually in two stages: the program coordination stage and the organic integration stage. The former consisted of a gradual approach to the institutions of the National Health System. The organic integration consisted of the merger of Secretaría de Salud local offices, a federal program operated by IMSS targeting deprived rural and urban areas, and services provided by the states, to establish Servicios Estatales de Salud (State Health Departments) run by state governments.

The decentralization process adopted elements of its development according to political, legal, and administrative policies in each state: in the political arena, guidelines were developed to define the decision-making capabilities of state governments and the regulatory role of the SSA. In the legal area, hygiene and sanitation responsibilites were distributed through Ley General de Salud and through coordination agreements. The administrative area was enhanced with organic structures, transfer of human resources, allotment of buildings and equipment, shared funding for health care provision, and other support to State Health Services.

The six components of the decentralization model were:

-Competency. This component involved the devolution to the state of the direction, coordination, and operational implementation of medical care, public health, and sanitary control of the concurrent general health services.

-Administrative. The structure in charge of operating State Health Services was created.

-Patrimonial. The federal infrastructure was transferred at no cost to State Health Services.

-Occupational. Workers were protected under the labor and social security scheme and the employers' individual faculties were delegated, while honoring their rights.

-Financial. A co-financing system was set up with federal and state contributions.

-Logistical. A mechanism was established to provide technical and logistical support required by decentralized services for their consolidation and better development.

At the central level the Health Cabinet was created. This is a collegiate board assembled to formulate, coordinate, and evaluate federal health policies and programs. The Committee for Decentralization of Health Services for the General Population was established to implement decentralization policies and strategies. The National Health Council was created by Presidential Resolution in March 1986 as a coordination office between the federal and state governments to perform program, budget, and public health evaluation activities for decentralized health services. To this end, this agency holds quarterly meetings.

Between 1985-1987, as part of the first phase of decentralization, 14 states signed the Agreements for the Organic Integration and Operational Decentralization of Health Services. In the second phase, the remaining states signed the same Agreements, so that in theory, all the states had been decentralized by 1995. The decentralization process required work strategies, a program of activities, and a strengthening of state services. Each state prepared a status report on its operative condition to assess priorities and necessary actions to improve its managerial capacity. A training course on decentralization was given that also included IMSS-COPLAMAR. The strategy of consolidation consisted of a set of actions to improve the substantive programs, as well as their proper organization and operation.

As has been pointed out, the coordination between the two health care systems for the uninsured population and the state health services has been difficult since their establishment. Duplication of functions is the untoward effect, as well as unnecessary omissions, and a managerial model that suffers the ailments resulting from centralism, overgrowth, and the bureaucracy of a massive structure that should stop obstructing local initiatives. On this basis, and consistent with the Program for a New Federalism, decentralization was sought for federal resources earmarked to caring for the uninsured --

Secretaría de Salud and IMSS-Solidaridad. This decentralization process did not consider neglecting national health objectives and strategies, but it did imply a new form of relationship between federal and state authorities, to establish goals and accomplish objectives.

In the context of decentralization of health services, it was necessary to define a set of essential health activities to assure the provision of a group of minimal health care interventions. This set of interventions represent a minimal commitment accepted by the states to meet the health policies, goals, and national objectives. In this setting, the decentralization process posed a clearer definition of its goals and responsibilities, which in turn would allow a more precise follow-up on the effectiveness of health policies through restructuring evaluation systems.

2.3. The health system in the contemporary era: transitions and the present structure.

The institutional diversity of the health sector and its resulting selective coverage is compounded by segregation in the provision of health services. More articulate industry and urban groups were given preference due to their greater social leverage. There are severe limitations for extending health services to rural populations and to the informal economy population. The predominant Flexnerian health care model that was adopted in Mexico became an additional obstacle to extension and equity of health care coverage. It has been acknowledged that this model gives precedence to the individual rather than the community and targets the disease rather than the healthy individual. As a result, the dependence of the model in relation to top-notch technology on one hand, and the limitation of its area of action at the individual level on the other, became in a few years a formidable obstacle to extend health care coverage.

Since their inception, health care institutions were oriented towards caring for different populations; this is the reason why their functional articulation is a very complex task. In the last two decades, the Mexican government has carried out a number of reforms and adjustments to the health system. These actions aim at developing a highly accessible health system characterized by universal coverage, and with a high technical and financing efficiency. Nevertheless the diversity of institutions within the health sector presents obstacles to accomplishing those goals.

In addition to problems hindering the organization of the National Health System, new problems have emerged related to the accelerated change of the epidemiological profile. In a few years, population growth and its parallel, aging, will result in a greater demand on, than supply – which is almost the case in the present – of hospitals and resources for high complexity health problems. At the same time, the question that must be asked is whether society is ready to deal with a growing number of elderly and disabled people.

It should also be considered that in Mexico, the private health insurance market is just beginning to develop, with the advantages that managed health insurance has. This is a submarket that the new National Health Program 2001-2006 intends to regulate, but at the moment there is no clear and effectual regulation in place. The present private health care market is one with no prospective payment; it has no protection mechanisms for families

facing extraordinary health care costs. It is characterized by low quality and efficiency. Its counterpart, the public medical care system is still run by multiple institutions that, despite unquestionable accomplishments, face decreasing quality, effectiveness and efficiency, overlapping services, and insufficient coverage.

The present structure of the National Health System is closely coupled with production modes. Formal economy salaried workers have access to social security institutions, while the remaining population is taken care of by public institutions such as SSA and IMSS-Solidaridad program. The latter have mixed funding from federal, state, and users' out of pocket monies, through reimbursement fees according to social strata. Social security funding depends primarily on contributions from workers and employers, and are complemented with federal funds. State workers, either at the federal or state level, are covered by diverse social security institutions (ISSSTE) a subsector whose funding comes from state and workers' contributions. In brief, Figure 1 shows that the coverage, funding amounts, and other distinctive characteristics of the current health system do not match -- as will be discussed later -- with the original policies and strategies of the Mexican Health System.

2.4. Challenges to the health system: the epidemiological transition and selected health indicators

Mexico's epidemiological history clearly reflects the times of rupture, achievements, and transitions that have been described in the prior chapters. Starting in the Conquest era, the epidemiological pattern in Mexico was characterized by epidemic diseases; this pattern persisted throughout several centuries with little change. Typhus, smallpox, the plague, and yellow fever were some of the main individual and public health problems in Mexico. The arrival of vaccines contributed to the change of this communicable disease epidemiological pattern.

In the present, the main characteristics of health transition in Mexico include the epidemiological transition. Indeed, considering Mexico's social development conditions, it should be noted that a high degree of communicable disease control has been achieved, and that chronic diseases rank high in the morbidity and mortality statistics. From a risk perspective, it is evident that the age groups in the extremes of life -- after taking into account a decrease of mortality among children from communicable diseases -- are readily exposed to risk factors not fully expressed in the past.

Those risks may be grouped in two blocks: a) risks encountered when the life span of children increased after controlling premature death causes -- becoming manifest as diseases related to the internal imbalance of the organisms, and b) risks that have replaced communicable disease risks -- mainly social, psychological, and education-related risks. Accidents and malnutrition are examples of these risks related to the economic, educational, and cultural characteristics of families.

The increasing rate of accidents is a good example of those risks; up to 1970, accidents were not included within the ten main causes of child mortality; in 1980 and 1990, accidents were ranked in the eighth place. The changing epidemiological patterns are closely related to the

demographic transition process in Mexico. Between 1940 and 1994, important transformations of the morbidity-mortality structure have occurred, placing the country in an intermediate rank between highly and poorly developed countries. Such changes are in turn the result and consequence of development and its trends point to the need for reformulating the strategies to improve the health conditions of the population. One of the prominent changes is the persistently high incidence of infectious and parasitic diseases.

Between 1940 and 1970, intestinal infections, and pneumonia and influenza ranked first and second as causes of morbidity. In 1940, rates for these diseases were 491.2 and 381.4 per 100 thousand persons, respectively; in 1970, they decreased to 149.4 and 173.5, and to 11.2 and 21 in 1994. In 1940, these two causes alone accounted for 37.4 percent of the total deaths; in 1998, this figure fell to 7.0 percent.

In 1940, heart disease and malignancies ranked in the 12th and 18th places and their rates were 54.3 and 23.1, respectively, while the rate of diabetes mellitus was 4.2 and had no place within the 20 main causes of mortality. At that time, these three conditions accounted for 3.5 percent of the total number of registered deaths in the country. In 1970, they ranked 3rd, 5th and 15th within the main causes of mortality and their rates were 69.4, 38.1, and 15.5, respectively, accounting for 12.2 percent of the total number of deaths. By 1994, they ranked 1st, 2nd, and 4th, with rates of 67.5, 51.5, and 33.7, and accounted for 32.8 per cent of the total number of deaths, nine times more than its burden caused in 1940. A similar situation occurred for accidents and injuries. In the last few years new diseases have emerged, like AIDS, and old diseases that had been eliminated, like cholera, have reappeared.

Analysis of these indicators shows that despite the great number of deaths that have been prevented up to the year 2000, there are still important delays. As in the case of the demographic conditions, the epidemiological transition process is also different among regions and states. In some states communicable diseases still rank among the main morbidity causes or have high rates, while in other states, epidemiological indicators are similar to those of developed countries, with a predominance of non-communicable diseases. The main epidemiological challenge in the next few years consists in delaying the arrival of chronic diseases aforementioned, to gain years of life and better quality of survival with increasing age.

2.5. Regionalization of health problems in Mexico: the burden of disease and priority health needs.

Several authors agree that one way to analyze corrected mortality is by state regionalization of health -- based on the relationship between the probability of dying among children under five years of age, and among adults aged 15 to 59 years. Disease in Mexico does not have a characteristic profile defining the country as a unit, but rather shows its regional heterogeneity. Taking that and the different epidemiological transition patterns into account, five possible regions exist in Mexico:

a.- Advanced transition. Includes states with low infant and adult mortality (mortality below the national average). It is comprised by nine states: Distrito Federal, Nuevo Leon, Tamaulipas, Sonora, Coahuila, Baja California Sur, Sinaloa, Aguascalientes, and Nayarit.

b.- Intermediate transition. Includes six states with low infant mortality and high adult mortality. States: Baja California, Chihuahua, Colima, Jalisco, Tabasco, and Morelos.

c.- Incipient transition. Occurring in states with medium infant mortality and low adult mortality. It is conformed by seven states: San Luis Potosi, Zacatecas, Guanajuato, Tlaxcala, Campeche, Yucatan, and Quintana Roo.

d.-Differential underdevelopment. Two characteristics were combined in this region-infant mortality above the national average (yet below 75%), and adult mortality that is also above the national average. However, this profile is much more common in rural areas than in urban areas. States: Durango, Michoacan, Queretaro, Veracruz and Mexico State. The five central states that are from this region display a higher disparity between their rural and urban areas.

e.- Extreme underdevelopment. It is characterized by the highest infant and adult mortalities (both of which are above national averages). States: Hidalgo, Guerrero, Puebla, Chiapas, and Oaxaca. The states in this region are the most impoverished and are located to the south.

Both national criteria and this regional heterogeneity should be taken into account when determining priority health needs. To demonstrate this heterogeneity, several authors have evidenced the regional variations in AVIS lost by age groups. It has been established that the order of the main health necessities varies by region, and that affinities among regions are minor. Homicide, accidental injuries (car crashes and run-over accidents), and liver cirrhosis are priority health needs that are equally common at a national level. Acute diarrhea, pneumonia, and malnutrition are quite irregular around the country. These are the main causes of death in areas of extreme underdevelopment, while in advanced and intermediate transition areas they are placed after the 8th major cause of death. On the contrary, ischemic heart disease, diabetes mellitus, and ECV are among the first five major causes of death in the advanced transition regions, while in the extreme underdevelopment regions it is placed after the 10th major cause of death.

To further demonstrate the irregularity of disease distribution in Mexico, it should be noted that the burden of disease is greater in states in the extreme underdevelopment regions. In fact, they claim over 30% of the burden of disease although they account for only 20% of the population. The most important state-to-state differences refer to the proportion of DALYs lost by age, and causes of disease. Only eight states of the country account for over 50% of DALYs lost in the population under 15 years of age, while the national average is 41%.

In contrast, five states account for less than 30% of DALYs lost in that age group. The analysis of the association between health needs (measured through the burden of disease) and social deprivation (marginality, measured through an index that scores dimensions,

shapes, and forces of exclusion from development), has led several authors to conclude that: the marginality index (MI) accounts for 60% of the variation in the burden of disease among Mexican states. Regarding the proportion of the burden of disease that would not be accounted for if disability was not considered, about 1 million DALYs lost correspond to the population aged 15-44 years, with a high proportion (75%) due to disability. A third of the nation's burden of disease is found among the young adult population (15-44 years) -- two thirds in males and the remaining third in women.

The burden of disease in Mexico shows a slight predominance of non-communicable disease over the other two main groups of causes of disease. Nevertheless, when specific causes of disease are broken down, accidental injuries are the most important, particularly motor vehicle accidents (vehicle crashes and pedestrian run-over accidents). The risk of losing one DALY due to motor vehicle accidents is two times greater than that for liver cirrhosis, and four times greater for diarrhea.

Finally, it is important to reiterate that the burden of disease in Mexico is unequally distributed. The burden of disease is greatly scattered among children, staying within the expected values for Latin America. In contrast, the distribution among adults is similar to the world's distribution, since some state have values similar to those of India, and others to those of European countries.

3. THE POLITICAL DIMENSION OF THE HEALTH SYSTEM: ACTORS, PROGRAMS, STRATEGIES AND REFORM PROPOSALS

The production of health services in Mexico is not only determined by the market, neither is it determined solely by the ideological commitment of the State to improve the life conditions of the population, but is also determined by political issues aimed at preventing social unrest, keeping stability and strengthening the legitimacy of the government. Thus, Mexico's health institutions serve a double purpose: enterprises that provide services and benefits with an intense political component, using health as an arena of political exchange between the State and society.

The current discourse of Mexico's ruling classes declare over and over again that there is a need to reform the State. This proposal provides an opportunity to include the institutional reorganization of the National Health system in that agenda. While reforming the national health system would have a positive net result for the country as a whole, several challenges would have to be resolved -- both inside and out of its field of action -- challenges that must be taken into account to increase the political feasibility of bringing change into effect.

In the health setting, particular care should be given to organized groups that play a political role as providers or users. They could be involved in the reorganization of the health system. From this perspective, this section describes the main political actors in the Mexican Health System, as well as the main political strategies for changing, adjusting, and reforming the health sector.

3.1. The political actors of the Mexican health system

Charting the political map of the health system requires the identification of the participating actors: health care providers and managers, users, state and federal governments, employers and workers, political parties, and the society as a whole. This section presents an approach to defining the profile of each one of the social groups affected by the regulation of health (see figure 2). In addition to the need for identifying the actors involved in the process of change and adjustment of the Mexican health system, it is fundamental to define their profile and role inside the health system. Following the proposal advanced by several authors, both aspects are presented, as follows:

-Employers: Employers are aware of the key role that the health system plays in the economic development of the country. Health expenditures have been shown to be determinants of the level of competitiveness both in the microeconomic and macroeconomic settings. Employers have expressed a high degree of dissatisfaction with the present organization of health services, and have been active in the formulation of reform proposals.

-State governments: Decentralization of the health system has caused reactions that depend on the political culture and social-economic development of each state. The variability of responses does not allow the typing of state government responses to this decentralization proposal. Each state reacts according to its technical and financial capacities.

-IMSS: The IMSS shares the opinion of reforming the health institutions, to improve their efficiency. Nevertheless, the IMSS is a vast and complex organization that encompasses groups with a diversity of visions and agendas regarding health system reform.

-Communication media: The media play an increasingly significant role in the political arena, by promoting citizens' participation in topics of public interest, particularly in the health area.

-Organized workforce movements: As was described in the first section of this document, access to health care is an important objective of union struggles, and is a topic in which workers are politically involved. Opposing views inside the universe of groups and organizations that are part of the movement result in an unclear definition of its view on the process of change currently pervading the health system.

-Political parties: political parties converge on the values that underlie the need for change in health. The different political platforms agree on the imperative need to assure access to health care for all the Mexican population, as well as to improve the quality of health services.

-Population unattended: Around 10 million Mexicans have no access to health care. This group would receive the most benefit from health reform, since it would be included in the health system.

-The President and his board: The main goal of the President is to accomplish significant developments in social well-being. To this end, central strategies include reforming two key social policy components: education and health. It should be noted that, given the type and

extent of interests involved in the health area, the personal and direct support of the President is a required condition to launch any health system reform initiative, a fact that has been proved by the new administration that began in 2000.

-SSA-Federal government-. The willingness to change the Secretaria de Salud is apparent because the current Minister of Health (representative of the Federal government) has advanced a health reform proposal inclusive of the different actors that have been described in this section. Therefore, the political will and disposition are set to facilitate reform with technical and collaborative support. In this context, the SSA will provide the leadership for conducting and implementing the process of health reform in Mexico.

-Unions: Unions involved in institutional change of the health system have a high number of active members, as well as national coverage. They negotiate at the central level of government.

-Civil society: The increasing importance of social actors becomes clear from their demands for health care as a constitutional right, for high-quality services, and for the freedom to choose a given health care provider. The new strategies of the national health program have raised expectations for a democratization of health services.

Finally, it is important to highlight that all health systems reflect the particular social and political conventions among participant actors -- particularly between the State and society. In the past, Mexican corporatism regulated the social and political dynamic between the state and society in order to preserve social stability.

The Mexican health system must be dynamic if it is to adapt to this changing environment. The health reform initiative is therefore a highly political process. The successful design and implementation of the new health policy strategies will require extensive consensus development among all the political actors. These new conditions call for a plural and universal health care system, where all involved parties benefit -- from health care providers, to employers, governments, and above all, users of health services.

3.2. The recent political strategies of the Mexican Health System.

The main changes of health policies in recent years may be analyzed through five categories: extension of coverage, municipal participation, implementation of a basic health package, reorganization of health care services, and creation of a national health system. Regarding extension of coverage, the main strategy is to extend coverage of social security. This is to be accomplished through users' choice of a health provider, greater quality of services, a new scheme of affiliation, and a reduction of employer and workers' contributions, along with a greater contribution by the government. These strategies are aimed at mostly urban populations who are outside the formal economy. To this end, the Social Security Law would be modified to create the family health insurance program.

This is the reason why one of the central objectives of health care reform is to increase governmental participation in health care funding, which would reduce users' fees for informal economy workers as well as for formal economy workers and employers. Lower

users' fees imply a greater access to health care through voluntary affiliation to health care services. At the same time, lowering users' fees allows a greater connectivity with the health insurance market, since those who do not want to use these services may opt to obtain services through reversion of social security fees, which is currently very limited due to its financial drawbacks on disease and maternity health insurance.

It should be noted that this proposal does not involve the loss of the income redistribution element that is characteristic of Social Security in Mexico. As financing draws from more general funds, the progressive character of health services is assured. These conditions will enable social security to grow and strengthen; therefore, the system as a whole will become more equitable and efficient. Regarding municipal involvement in health, the participation of social groups, non-governmental organizations, and other institutions is a central element to maintaining the public's health. In this regard, the Healthy Municipality strategy becomes the leading mechanism of activities that foster the collaborative work of the community in priority-setting, local health programming, and operation and evaluation of program activities.

This strategy will contribute to improving the population's health by conducting projects developed in collaboration with different social sectors at the state and municipal levels. Using this strategy, it will be possible to inform and advise all municipalities in the country on the relevance of community organization. This will allow the inclusion of health intervention projects carried out by the community in the majority of municipalities of the country. The training of health personnel required to implement this strategy will be an additional asset.

Extension of coverage through a basic health care package aims at providing services to the nearly 10 million Mexican citizens who have no or limited access to health services. To assure equity and social justice, health care reform establishes a primary objective to reach that population group with basic health services, at the same time propping up the Programa para Superar la Pobreza (PROGRESA, Program to Overcome Poverty). This strategy is based on the implementation of a "Basic Health Package", defined as a set of basic health care interventions that should be delivered to this population to cover their basic needs. These are interventions that may be implemented easily and cost-effectively to curb the main causes of death and disease in underserved groups. Consistent with decentralization, this strategy of coverage extension sets objectives, goals, and straightforward guidelines for the country as a whole, but with an operation decentralized to the states and municipalities.

The strategy of reorganizing the health care system assumes that the current health system segregates the population, separating it in a way incompatible with its geographic and economic characteristics. This model should then be reorganized following a new logic. Social security should be extended where the income level makes it possible to set up a scheme with lower fees, as well as users' freedom to choose their health care providers, notwithstanding the formal or informal economic status.

Where it is not possible to establish prepaid health insurance schemes, health care institutions for the general population should still provide services without duplication of coverage, operating in a comprehensive and decentralized way. Reform of public health

services for the insured population and the population at large will be rather radical in that it will bring to an end duplication of services and will extend coverage of essential health interventions with greater efficiency and better organization.

The four strategies aforementioned were the pillars of the original reform initiative advanced in the 80s, including the 1995-2000 National Health Program. Additionally, a new reform project has been recently presented which recovers those strategies -- now included in a scheme of ten new strategies. These ten strategies will be pivotal for the production and financing of health services towards a universal health system. The ten strategies of the new National Health Program for 2001-2006 are:

-To link health to economic and social development;

-To reduce health system gaps that affect the poor;

-To deal with emerging problems by expressly establishing priorities;

-To launch a national crusade to improve the quality of services;

-To build a new cooperative federalist health system;

-To strengthen the leading role of Secretaria de Salud (SSA);

-To advance towards an Integrated Health Care Model (Modelo Integrado de Atención a la Salud);

-To strengthen investments to develop human resources, research, and infrastructure;

-To promote community participation in health and the free choice of medical care centers;

-To strengthen the investment in human resources and research.

This health program, originally proposed for implementation during the 2001-2006 period, also has long-term strategic planning objectives. Basically, its objectives are to solve the equity, quality, access, and coverage problems of the national health system. Moreover, it includes a proposal to provide financial protection for users, particularly for the poorest. It should be mentioned that the National Health Program, officially presented in July 2001, provides an extended vision on health for 25 years. Regarding building a cooperative federalism in health, the Program acknowledges that there should be an equitable distribution of health resources. Financial resource allocation criteria and mechanisms should be reviewed to address inequalities among states, institutions, population groups, and levels of care. It is known that health resource allocation to the states is still based on historical expenditures, which does not necessarily parallel the health needs of the population or assure the proper distribution of economic resources.

Regarding financial protection, the proposal for a universal health system is to strengthen funding and discourage out-of-pocket fees. This will be accomplished in three ways: to establish the popular health insurance, to extend affiliation to IMSS, and to rearrange and regulate private health insurance. It is anticipated that with these three alternatives, all Mexicans will have access to health care. The popular health insurance – with has been detailed by now, will be the basis for national health insurance. Its target population will be low income households that will have access to the IMSS Family Health Insurance through a tiered subsidy, according to ability to pay.

The new health care model, according to the government project, is designed to be a new comprehensive health care model (MIDAS) that will cover 98 percent of the population by 2006. It will assign users to a family doctor who will serve as the health manager for his or her patients. This model of care assumes that hospitals will become autonomous establishments and that financing be assigned to users and not to health care providers. This model of care will be, in summary, the Mexican version of the competitive market model, both public and private, offering service packages according to insurance fees, under per capita payment to the health fund manager agency. The final purpose, in brief, is to create and operate a universal health system. The strategies, as well as the guidelines of the new National Program of Health 2001-2006, will be re-examined in the discussion and conclusions section, to elaborate on the feasibility and potential scope of the new and recent national health system policies.

3.3. Reform proposals in the various health institutions.

The health reform process is currently underway. Changes intended for the IMSS were formulated in a new law in December 1995, after a long debate that began in March of the same year. Although the IMSS reform entails important changes for health services, it also involves a wider strategy of economic recovery in a complex financing system whose main objectives are to encourage internal savings and create employment. However, this gradual process is just beginning and there is still a long way to go. Successful implementation will depend mainly on how reform policies are put into practice. The perception of changes and their potential consequences will cause disagreements, and will require negotiation and consensus development among participant actors.

Regarding health care for the insured population, the changes advanced in the new Social Security Law aim at recovering financial strength for the disease and maternity insurance programs, to extend coverage, and to improve IMSS health services. Even though pension system transformation pretends to serve as an important source of internal savings, it also will have significant consequences on IMSS health services. Pension funds for disability, old age, retirement, and death (IVCM) have been used traditionally to cover part of the disease and maternity insurance funding deficit, as well as to finance a great portion of medical infrastructure.

This source of financing is lost with the new system of pensions. Other sources must be tapped. One of them is through a new scheme of fees that replaces the previous one that charged the payrolls through a mixed contribution of a single payment by the employers and the government, to cover all the workers. This was complemented with employer and

worker contributions, as well as an increasing governmental fee. Another funding source is the new family medical insurance. Voluntary affiliation to this scheme seeks to cover all those individuals with payment capacity who do not belong to IMSS. A third funding source is the new disability and life insurance, allocated to medical expenses for retirees, costs that are expected to grow considerably in the next few decades.

Regarding health services for the uninsured, the basic changes in the SSA are decentralization of services for the uninsured, along with integration of SSA and Program IMSS- Solidaridad services (Secretariat of Health, 1995). After previous experiences at the end of the 80s and the beginning of the 90s when the reform process was almost stopped, the present extension to all federal organizations and the growth of financial transfers to state governments have become central strategies in the past few years. Its main objectives are to lend greater efficiency in system performance through better resource allocation, to enhance the administrative capacity of operative units, and to have a greater transparency in the distribution of responsibilities. It also aims to extend coverage to groups currently marginalized by providing a basic health care package. In addition, a formula will be applied to allocate financial resources among the states in proportion to their health needs.

4. CHANGES AND TRENDS IN HEALTH PRODUCTION AND FINANCING POLICIES IN THE CONTEXT OF THE NEW FEDERALISM

4.1. Main changes included in the reform proposals

The scheme for the insured population will undergo deep transformations regarding the production and financing of IMSS health services. The most important are:

- Change of the previous payroll tax by a mixed contribution: a unique quota paid by the employers and the government for workers making up to 3 times the minimum wage. This is complemented with proportional contributions for employees who make more than 3 times the minimum wage.

- Increasing dependency on general tax financing, paid for by the previous payroll tax, and earmarked for social security. Fee return (reversión de cuotas) for companies that procure health services for their employees.

- Change of premium charges to cover work risks.

- Freedom to choose the family doctor in order to improve users' satisfaction and introduce incentives for the best performance of health care providers.

- Greater flexibility, through IMSS voluntary insurance, to provide health services to those insured under other schemes.

Concerning the uninsured, the main changes proposed are:

- IMSS health care coverage to groups traditionally excluded from social security by establishing a new one-family medical insurance, which will be subsidized.

- Accomplishing health care decentralization for the uninsured by extending them to all states, and strengthening funding transfers to state governments, followed by unification of services currently provided by SSA and IMSS-Solidaridad.

- Extension of coverage to marginalized groups by providing a basic health care package.

4.2. Considerations on the effectiveness of the changes and present tendencies of the reform of the sector

Since these are changes that fundamentally affect the IMSS, the following considerations on budgetary effectiveness should be made: The new financing strategies may lead to fiscal deficit for both the IMSS and the federal government. It is advisable to assess diverse financial scenarios in detail to prevent any potential deficit. The increasing financial dependency on general taxes will present an unprecedented situation to IMSS -- the need to meet competition -- when in the past it enjoyed an almost exclusive and protected funding allotment. It will be necessary to devise fair and efficient mechanisms to avoid yearly negotiation of federal allocations with Secretaria de Hacienda (Internal Revenue Service).

The risk of financial uncertainty can be reduced by the estimation of multiple-year budgets and/or the approval of earmarked taxes (like the so-called “sin taxes”, such as alcohol or tobacco taxes). Fortunately, the new IMSS law clearly states the financial obligations of the federal government. Timely fulfillment of such obligations will allow the uninterrupted flow of necessary resources to guarantee the operation of services.

The fee return scheme requires careful monitoring, because it could have adverse and lasting effects on the general economy, the companies, and the health system. If well managed, it will become an asset; if not, it could have deleterious effects on the health system, as well as on the economy and the social welfare, just as has occurred in other countries like the United States.

As for changes concerning mainly the Secretaria de Salud at the federal level and its relations with counterpart offices in each state, the main issue is the structuring of the decentralization process. Two subjects deserve particular attention: adequate financial solidarity must be preserved among states. Given the remarkable disparity among states, decentralization may itself worsen the inequalities. The states with less resources – which also have the worst health conditions -- are usually at loss in organizing health care and acquiring the indispensable financing.

A way to advance decentralization while preserving solidarity is by means of a numerical formula that allocates financial resources among states proportional to health necessities and sectoral underdevelopment, so that the present gap between rich and poor states is reduced. Decentralization must serve to generate a true structural change, avoiding the mere replication of the present public monopoly scheme in the states. It would be unfortunate if decentralization multiplied present federal-level inefficiencies. One could hardly speak of progress if the country were to go from having an upgradable federal system to having 32

inefficient state systems. Thus, decentralization must serve as a driving force of the new institutional configuration the Mexican health system.

5. FINANCING HEALTH SERVICES IN THE CONTEXT OF THE NEW FEDERALISM: ORIGIN, TRANSFORMATION AND CURRENT TRENDS

Even though the fiscal system and financing flows among the different government levels in Mexico take place in a setting of open federalism, signs of the particular type of federalism discussed in the first section are evident. Indeed, the financial flows from higher levels of government to lower levels are intended to maintain a centralized system. Equity, efficiency, and effectiveness are far from being the predominant criteria for proper resource allocation. This section describes in detail the mechanisms and systems that generally regulate the finance flows among the different government levels and particularly among the different health system subsector.

5.1. Finances at the federal level

The office in charge of contributions is the Coordinacion General con Entidades Federativas, Subsecretaria de Ingresos, Secretaria de Hacienda y Credito Publico (SHCP). This office issues federal government checks every month to state and local governments, for amounts calculated with a formula of automatic transfer. Additional components are included for fund collection. These components are part of a formal system of federal tax collection, which has never been sufficient to cover state and municipal health expenses.

The system was recently modified and established in the National System of Fiscal Coordination (SNCF) -- the legal body which manages contributions in Mexico. The SNCF organizes and regulates the fiscal system, to protect citizens against unfair taxation. In the past, there were some cases of double and even triple taxation on the same source of income. Since 1980, states and municipalities were authorized to keep a portion of total federal tax revenues. Among the most important are the income tax (accounting for nearly 43% of the federal tax revenue), the value added tax (about 28% of the federal tax revenue) and a special tax on selected products and services (about 20% of the federal tax revenue); the remainder comes from other sources.

The system was modified once again in 1990, when the current guidelines were established. Before the 90s, formula-estimated contributions were distributed among states through three funds: the 1) General Contributions Fund (FGP), collecting 13% of the total annual federal government tax revenue, which was then distributed among the states in proportion to their contribution to federal tax revenue; 2) Complementary Finance Fund (FFC), a complementary fund derived from the same tributary base as FGP, therefore receiving smaller allocations from that fund, and 3) the Municipal Development Fund (FFM), made up of 1% of the additional tax to oil and natural gas exports, allocated exclusively to the municipalities.

During the reform of the 90s, the first two funds were joined and are still called FGP. Until late 1997 taxes collected in the states were sent to Mexico City to be included in the Federal Sharing Collection (RFP); 18,1% of it was distributed among the states as FGP. Twenty

percent of the FGP was distributed among the municipalities. The FFM included 0,42% of the RFP and was allocated to the municipalities. Hence, the states are given 18% of the federal tax revenue, 22,1% of which must be distributed to their respective municipalities.

5.2. Finances at the state and municipal levels

The state financial systems also operated according to the Law of Fiscal Coordination (LCF). Nevertheless, different states manage their finances in different ways, within the limits imposed by the LCF. State legislations determine their own tax policies and collection. The LCF clearly states that at least 20% of the total amount of federal contributions transferred to the states must be given to the municipalities. In addition to federal allocations, the most important income source, all the states collect their own contributions from different sources, mainly taxes and licenses (public service fees). Among them, the most important are land and water fees in addition to license plates, civil registry, and public events).

These contributions constitute the majority of patrimonial goods and royalties. The municipal governments of Mexico collect two types of revenues: ordinary, or conventional; and extraordinary or complementary. In sum, ordinary income comes from contributions, taxes, public service fees, and government assets. Extraordinary revenues include funds received by city councils from the federal and state governments as subsidies and other contributions for public works, operation deficits, and contingencies.

5.3. Resource transfers and the new policy of health income and expenditures

After signing the health decentralization agreements, the federal government pledged financial resources for state and municipal governments for the operation of health services following these guidelines:

Material resources and supplies. The federal government agreed to transfer material resources and supplies from the budget year 1996. Sixty-six percent of the budget for material resources and supplies were earmarked for purchasing drugs and minor surgery materials. States were allowed to make consolidated purchases and pay upon receipt. This helped to control the quantity, quality, specificity, distribution and shelf life of the merchandise, as well as improving supply efficiency.

The federal government was committed to providing the states with resources earmarked for purchasing drugs required in vertical programs. A portion of those resources were to be kept by the federal government to cope with emergencies. The remaining inputs consisted of overhead materials, food and fuel expenses, and linens. They were included in a budgetary partition to each state. The independent management of resources derived from partial reimbursement fees by the states, as well as the carrying out of public welfare programs by the states, were both approved by the National Health Council.

Today, state health services have the authority to regulate and operate a local system of partial reimbursement fees. Currently, a new income-spending policy favors the financial self-determination of the state health services. Partial reimbursement fees are devoted to

high-priority spending towards the continuous improvement of the quality of health services and to satisfy the local health needs. In sum, the states and municipalities should be able, in theory, to assume the faculties and functions that have been transferred to them. This should give them more latitude to allocate resources, while assuming new and greater responsibilities to finance the health services they provide.

Along these lines, partial reimbursement fees received by health care units are consistent with a state and municipal health financing strategy. These funds have covered growing financial gaps, and have contributed to preserving state and municipal medical care services. Having fiscal autonomy on partial reimbursement fees results in greater effectiveness of health programs, and higher capacity to handle emergency situations, depending on the political and technical conditions of each state, as will be discussed below.

Another commitment established by agreement of the National Council of Health refers to the design of public charity instruments in the states, to regulate and operate a local system of partial reimbursement fees, and at the same time, to make or support specific actions of public charity to promote the collection of financial resources and generate new health financing alternatives at state and municipal levels. Finally, changes in health care financing are proposed in the new 2001-2006 National Health Program. However, it is unclear what the new funding sources will be, and what financial flows or financial allocation mechanisms will be implemented within the new integrated health care model.

5.4. Effectiveness of changes and recent trends in health financing policies in Mexico

The following are empirical findings of a study to identify the effects of changes in health policy financing and trends from the inception of decentralization to the reform of the health sector in the last 10 years. This study was conducted in four states of the country, selected from a random sample stratified by the marginalization index, phase of reform and decentralization, per-capita income, and ruling political party in the state and the municipal governments. These findings show the financing flows by expenditure trends for the insured and uninsured populations. The analysis of financial flows for the uninsured population shows the behavior of the different funding sources for the four selected states. The financing sources refer to federal, state, municipal, and users' contributions (see Figures 1-8).

Firstly, it is necessary to highlight that the effectiveness of financing policy changes within the state reform, and particularly within the health sector reform, is quite variable depending on a given state. Indeed, there are states where increases in financial amounts are greater than in others. This is not closely related with per-capita spending in health nor with the health needs of the population. For example, the state of Oaxaca is one of the states with one of the highest marginalization indices in the country. However, it is the least favored by an increase of health expenditures.

Secondly, the analysis of health expenditures and the percent distribution of the different financing sources shows a more irregular situation than the one aforementioned. Indeed, changes in the legal framework to adapt the health system to local health needs has shown different levels of effectiveness in each state of the country. For example, if we compare the

state of Tabasco with the state of Yucatan, it is noticeable that the Tabasco state government has an important participation in health financing, whereas in Yucatan nearly 100% of health expenditures depend on the federal government, even though the state should have, in theory, a participation of at least 30% of the health expenditures. The same it is observed in the states of Oaxaca and Hidalgo, where most of the cost in health continues to depend on the federal government. Nevertheless it is necessary to highlight that in these two states there is a relatively significant participation of the users in the financing of the services of health. This last issue is very contradictory, because in both poor states of greater social marginalization there is a significant participation of users in paying for the cost of health services, in relation to the other two states of smaller social marginalization.

6. DISCUSSION AND CONCLUSIONS

In the last few years, Mexico took important steps towards democratization in the context of a new federalism. The democratization concept implies the application of citizens' norms, values, and procedures to governmental institutions, among them the health institutions that were or are steered by principles of centralist control, judgment, or administrative practices of the state bureaucracy. Several structural changes have greatly influenced democratization:

- Strengthtening and increasing civil society's autonomy resulted in the multiplication of popular and nongovernmental organizations, as well as the competitiveness and professionalization of the mass communication media. This new role of civil society also exerted important effects in the loss of governmental control on the media, the access to information, as well as the reframing of intergovernmental relations, of the power structure, and of the new state-society relation.

- Mexicans have had greater participation in the electoral process, which now has greater transparency and credibility. Since 1994, the Electoral Federal Institute, an independent institution, was in charge of enforcing the rules of the electoral process. In the 2000 and 2001 elections, the opposition gained presence in different government levels. Power turnover, at federal and state levels, exposed the mechanisms of corruption of the previous administrations, and has resulted in conflicts and rearrangements of the power structure.

- In recent years and particularly since the year 2000, important power changes have taken shape within the different political parties. Congress has become more active in issuing law initiatives, and more independent in relation to the executive power. However, complete transformation has not been consummated; the Mexican political system is still dominated by the President. Most analysts think that this must change in order to increase democratization across the different government sectors, including the health sector. Indeed, consensus on the democratization of health is shared among different political actors involved in health issues. Nevertheless, consensus development is obstructed by the power structure, by the distinctive characteristics of federalism in Mexico, and by the particular characteristics of the National Health System as it is today.

In spite of the democratization developments and the reframing of intergovernmental relations in the context of the new federalism, the President and his top aides are still in command of the power structure in Mexico. In fact, the President still exerts control over the state level through a number of formal and informal faculties. Although in principle the Mexican municipality is the governmental unit in charge of the local administrative processes, in reality, city council affairs, including health issues, have been traditionally limited by the state and federal government.

Recently, health decentralization agreements were convened by state governors, including one of the main conflicting issues: the transference of resources and responsibilities from the federal government to the states. This implies a redistribution of power that is easy in theory, but that in practice has not been consummated due to the lack of feasible mechanisms for the new power structure and intergovernmental relations.

Indeed, in the last few years, the state, the institutions, and society at large have not yet established clearly those new mechanisms for establishing their type of relations and the new rules of political exchange. Mexico is undergoing a key process in which several possibilities are being explored: a plural democracy with room for the participation of the whole population and a greater freedom of choice (including users' choice of health care provider, institution, hospital, or physician); or a less authoritarian corporatism, where social participation is constrained and guided by politically organized groups. Nevertheless, old corporatism obstacles still prevent this process from steady and unrestrained progress.

Two alternatives are possible for establishing conditions favoring health policy transformation in the country and the new mechanisms of exchange among the state, health institutions, and health care users.

One dilemma is posed by the lack of clear rules. Despite the persistence of old practices and agreements, society is increasingly showing that the corporatist array does not address all of its health concerns and demands. Important population groups that have been historically excluded from this contract are now politically active. For example, the informal economy sector that has been historically unprotected by social security now has the freedom to enroll a health care program for the insured population.

The second dilemma is faced by the state: whether to keep the corporative array, or to use more democratic mechanisms to steer individual wills and organized forces in the same direction of change, towards achieving better health conditions. As long as there is a perceived need for maintaining the vertical and centralizing mechanisms of control to carry out this sectoral reform, there will be less incentive to tear down the old corporative scheme. In the past, effective resistance to change in the health sector has blocked the reform initiatives, and only partial progress has been made, if any. In the health area, the main actors must see the agreements as legitimate and convergence should be reached among the groups and sectors participating in the process of health reform.

It is necessary that a collective agent play a coordinating role. This role could be assumed by the State. The position of key political actors on these dilemmas will outline the effectiveness of proposed changes in the health sector and the health reform agenda regarding the relations between state and society. If the old array is thought to be indispensable, practices of exclusion will be preserved, and population groups will still endure important limitations in health care quality, equity, accessibility, and effectiveness. But if change occurs, as anticipated by the National Development Plan and the 2001-2006 National Health Program, towards a more modern and fair political array, consistent with the plural society of Mexico, new health policies will be implemented, based on the principle of citizenship stated in the Constitution, and towards the creation of a universal health system.

The potential effects of health reform, particularly the increasing use of fiscal resources to finance social security, may occur at the expense of funding allocations for the uninsured population. This would result in a greater deficit for health programs for the population with lower income. Also, there would be greater inequity and less access. It is indispensable to evaluate the effects of health reform on social security financing, particularly of IMSS on

other health institutions. If necessary, corrective measures should be undertaken to prevent further inequity or weakening of public health programs that protect the population.
Regarding changes affecting the insured population, as the provision of health services is decentralized to the states, the SSA must assume the regulatory function of the health system as a whole.

The empirical findings that were presented to analyze the trends in the light of the new political strategies help us to show that the effectiveness of the change proposals for SSA financing policies is challenged by the findings showing the health needs of the population. According to policy guidelines of the national development plan and the national health program, a financial protection strategy should be established for low-income users; however, empirical evidence showed that low-income users end up paying more for health care services.

Moreover, the decentralization proposal intends to put an end to the customer approach and excessively centralist character of the Mexican government structures. The aforementioned findings show that the state and municipal levels still depend on the central level. There are a few exceptions. For example, Tabasco state has been able to develop financing and service production policies at the state and municipal levels more suitable for health conditions.

Regarding the health service production and market, the first section of this document established that health services, both public and private, are in the middle of a crossroads, marked by official reforms, organizational challenges and innovations, and by increasing citizen participation. These phenomena, implicitly in some cases and explicitly in others, seem to be irreversibly affecting health care provision. Although in the last fifty years public and private health care services have formally coexisted, the IMSS has been subject to reform pressures in recent years. The IMSS is the main social security institution of the health sector, with the greatest coverage in this country. These pressures are shaping a new pattern of relations between the public and private sectors.

Indeed, health services are under strong financial pressure, while their credibility is diminishing for its users. The National Health Service Satisfaction Survey showed that 47% of social security policyholders reported poor quality of hospital services and that 51% reported poor quality of first-level care services. Another survey carried out in 57 companies on employers' opinion of social security health care services showed that nearly 95% of them would be interested in joining fee return schemes. This means they would prefer to contract health services other than those offered by social security. One of the main reasons for this is that more than 90% of Mexican companies offer their employees (in some cases to all and in others only to top executives) major medical expense insurance and comprehensive health care services. The companies end up paying in duplicate for medical care: they pay social security and a private health care provider.

Both the financial pressures, and the pressures from employers and workers, underlie the interest of social security to extend the fee return scheme. This is a main trigger of transformation for the public-private mix. The trend towards greater competition between public and private medical care services could prove devastating for the health of the

population if unregulated. For this reason, the SSA will have to assume a regulatory role as stated in the 2001-2006 National Program of Health. Private health care in Mexico is a very heterogeneous sector; if ill-regulated, it may become a threat to the health of the population. For example, 36% of private health care units have no full-time attending physicians, and 16% have no full-time nurses. Despite considerable advances in the constitutional right to health protection the regulation of these suppliers has been rather loose, as there is no mechanism for a periodic quality-of-health certification.

Health care market regulation is closely related to the proposal for an Integrated Health Care Model. This new model of care intends that by 2006, 98 % of the population be assigned to a family physician, who will serve as the health manager of affiliate users. Hospitals should become independent units and financing should follow the user rather than health care providers. This model sees the public-private mix under a strict market regulation framework, and amounts to the introduction of the competitive market model of public and private services that will offer service packages based on the insurance premiums, along with a per capita payment to the health care fund manager.

Finally, it should be noted that the recent political proposals for health reform, in the context of the democratization of health with a new network of social actors, raise new challenges in terms of roles and scenarios, to the State, health care suppliers, and users. These roles and scenarios will be frequently in conflict; this will require constant consensus development. In this adjustment and search for consensus among health care actors, the feasibility of health policy strategies will require the generation, production, reproduction, and application of knowledge on the design, implementation, monitoring, and evaluation of health policies, organized along six research lines: extension of coverage; community participation and decentralization; implementation of the basic health care package; reorganizing the health care model; development of indicators for evaluating performance towards the creation of a universal health system; development of indicators of health financing policies, and specific mechanisms for financial allocation and protection for health care users, mainly for low income users.

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FIGURES