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The Mexican Health Care System: Moving Toward Managed Care

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The Mexican Health Care System: Moving Toward Managed Care

Mexico, with a population of approximately 85 million, is the second largest country in Latin America next to Argentina.[1] Sixty percent of its people live in urban areas, with the remainder living in the rural areas. Twelve percent of Mexico's people live in poverty. Mexico, as a developing country, is currently undergoing of a number of challenges to its economy and government, including to its health care system. Why is the Mexican health system of interest to the U.S.? The obvious reason is that Mexico and the U.S. share a border. With implementation of the North American Free Trade Agreement (NAFTA),[2] the incentives are even greater for these two countries to work together toward furthering trade and commerce. Under a new government (as of 1995) and a plan of health care reform, Mexico is looking to the U.S., as well as to Chile, as a guide for a health care delivery model as it moves away from its socialist model. In short, it is looking at managed care as a possible option.

The Mexican health care system, which has developed over time without the benefit of planning, is ripe for change.[3] The current structure precludes accountability and clarity in assignment of responsibilities, promotes inefficient distribution of resources, and discourages incentives for physicians to improve. Furthermore, the segmentation and lack of coordination between institutions has produced a duplication of services in some sectors, while other groups are not covered. Finally, the cost of health care is very high for employers, who, like American employers, purchase care for their employees.

As illustrated in Table 1, six government health agencies administer health care to Mexico's population. The Ministry of Health (SSA) reports to the President, who is responsible for planning and implementing the health matters for the entire country. Note that the SSA oversees all six agencies, while also having its own delivery "arm." Table 1 outlines, per each of these six agencies, the source of funding, the population covered, the geographical jurisdiction of that coverage, and whether the insurance coverage is "public, or "open medicine" (covers 33% of the population) or "social" (covers 53% of the population). Public coverage refers to services rendered for the poor and lower middle classes (i.e., the "working poor"). Social coverage refers to services available for the working middle class/those who have a secure job (i.e., at above-minimum wage earnings). Private (out-of-pocket payment) health care insurance covers 5% of the population. (Note that private health insurance is not addressed in the table.) Each of these agencies acts independently, has its own policies, organization, resources, and differing funding mechanisms. Approximately 9% of Mexicans have no access to medical care those who live in the most geographically remote, inaccessible areas, of which there are many in Mexico.

In 1995, the federal executive government established the National Plan of Development (NPD) (1995-2000),[3] targeting the health care delivery crisis as among its reform objectives. The objectives of this reform are: 1) to promote the quality and efficiency of health services, 2) expand the coverage of social security health care system to cover all employed and unemployed population, 3) to include health services for population without social health service, 4) to extend the quantity of and accessibility of health care to underserved areas, i.e., rural areas and population in poverty. The NPD aims to develop and establish a decentralized global budget that will allocate funds to each of the six agencies according to a formula based on indexes of morbidity, mortality and poverty, toward improving the efficiency and

equity of health care. As in the U.S., capitation is being looked to as the favored reimbursement mechanism for physicians.

Since 1995, Mexico has made great strides toward evolving its health care system under the NPD. The proliferation of managed care is proving to be positive, and today there are 15 managed care organizations (MCOs) in Mexico. Aetna/US Healthcare, which is also in Chile and Argentina, predominates, though Mexico is also looking to other U.S. MCOs as potential business partners. Among the challenges to be addressed in furthering health care reform will be the introduction of quality standards, such as those imposed by the National Committee for Quality Assurance in U.S. (Mexico does have a relatively new agency that serves as a mediator between providers and patients, in an effort to keep cases out of court) and other measures of quality, such as accreditation standards.

Extensive patient and physician education must also be on the national agenda. Patients will need to be enlightened as to their new options under managed care, and how to negotiate the system. Physicians must be incentivized to "buy into" the managed care framework, which is very different from the incentives that exist under the current social system of health care. For example, most physicians in Mexico wish to garner secure positions in the state or federal government, as private practice is extremely difficult to break into (due in large part to the vast majority of the population receiving health care through the public and social sectors). However, workforce constraints dictate that the state and federal government can only support 20% of residency-trained physicians. The emergence of MCOs in Mexico, and concomitant "shiftwork" available for physicians, promises to enhance physicians' employment and personal income opportunities.

These recent developments in Mexican-American relations will no doubt further opportunities for medical education, teaching, and research. For example, though not related to the aforementioned Aetna/Mexican collaboration, Mexico's National Institute of Neurology and Neurosurgery instituted a resident exchange fellowship program in which several residents from Mexico attend Jefferson Medical College for one year. A similar initiative exists to promote mutual knowledge of Family Medicine. Not least, an optimal outcome of this new Mexican-American health care collaboration will be the realization of improved employment opportunities for physicians. Central to these efforts will be the physician, without whose allegiance the best laid plans are sure to falter.

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