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The Rise and Fall of Priority Setting in Mexico: Lessons from a Health Systems Perspective

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Title: **The Rise and Fall of Priority Setting in Mexico: Lessons from a Health Systems Perspective**

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Preface

Since the early 1990s, researchers involved in the Disease Control Priorities (DCP) effort have been evaluating options to decrease disease burden in low- and middle-income countries. This working paper was developed to support the Fourth Edition of this effort. It is posted to solicit comments and feedback, and ultimately will be revised and published as part of the DCP4 series.

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The Rise and Fall of Priority Setting in Mexico: Lessons from a Health Systems Perspective

Abstract

Mexico's Seguro Popular (SP), launched in 2004, provided expanded health access and financial protection to uninsured Mexicans (41% of the population) via two health benefits packages (HBPs), comprising 294 essential and 66 high-cost interventions. However, the SP was repealed in 2020. This case study focuses on the importance of priority setting in health and the benefits of increasing access through HBPs, while also acknowledging the relevance of sustainability, providing valuable lessons for other countries. Priority setting strengthens health systems and informs UHC pathways, with investment in human capital and institutional development yielding significant gains that should not be underestimated.

Key messages

- HBPs support country specific pathways to achieve UHC by introducing an ordered way to decide and legitimize decisions on which interventions should be covered and for whom.
- Priority setting implementation is also pivotal to enhance health system performance.
- Considering sustainability and a long-term vision when implementing priority setting is relevant to preserve as much as possible its wider benefits, from a health system perspective.

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1.0 Introduction

With a 127 million population and a per capita income of 10,046 USD, Mexico stands as a large upper-middle country and the second largest economy in Latin America. It also ranks favorably in the human development category (HDI: 0.758). Life expectancy at birth increased substantially since 1970 but progress slowed since the early 2000s as it reached close to 75 years before the pandemic hit in 2020 (World Bank 2023a; UNDP 2022). Health challenges have rapidly transitioned from infectious to non-communicable diseases and injuries and at 73%, Mexico now has the largest share of overweight or obese population among OECD countries. Access to quality care measured by population coverage through an explicit health benefits package improved substantially since 2003, as a result of the Seguro Popular reforms. Yet, the health system has remained chronically underfunded with health spending averaging 5.8% of GDP over the past decade, roughly half of which is paid out of pocket (see Box 17.1). Consequently, Mexico has 2.4 doctors, 2.9 nurses and 1.0 beds per 1000 population, less than one-third the comparable number of the OECD countries. The most pressing challenge looking forward is to provide sustainable access to quality care to a rapidly ageing population without exposing them to excessive catastrophic spending (OECD 2021).

Mexico has a long tradition of using explicit priority setting to inform health coverage expansion, starting with international efforts to develop disease priorities in the 1990's and culminating in the 2003 creation of the *Seguro Popular* (SP, Popular Health Insurance). Soon after the launch of the landmark 1993 World Bank's World Development Report (World Bank 1993) promoting the use of burden of disease and cost-effectiveness to define a set of essential health care interventions, the Mexican Health Foundation (Funsalud), a health policy think tank, proposed a series of reforms, including an essential health benefit package (HBP) of cost-effective interventions to tackle the double burden of infectious diseases and emerging non-communicable diseases (Frenk 1994). This approach meant a break away from previous policy trends —which focused to a great extent on ad-hoc supply-side strategies to extend access to health care—, to a more equitable and rational resource allocation process to steer supply-related efforts towards increasing coverage in deprived areas (González-Pier, et al. 2006).

Box 1 Mexico's health system: key features

Mexico's health system dates from 1943 and its main feature has been the institutional fragmentation resulting in co-existing publicly funded health care subsystems. While salaried employees have access to social security institutions, the remaining 50% of the population is catered for by other public institutions including 32 decentralized services run by the states' governments alongside federally run general hospitals and high-specialty centres.

Only 30 years ago, the health needs landscape was characterized by a double burden of disease. NCDs were just emerging and communicable diseases, maternal and neonatal, and nutrition-related conditions were still a leading cause of morbidity and mortality, especially in poor populations. Mexicans now live 75 years on average and

population health needs are driven by an increasing burden of NCDs -mainly cardiovascular conditions and diabetes-, many of which are linked to a high prevalence of overweight and obesity. Slightly less than 75% of adults (20+) are overweight or obese and 1 in 5 children are obese.

Total health spending as a share of GDP has increased from 4.4 in 2000 to 6.2 in 2020. Although positive, this still falls behind the average of OECD countries (9.9 in 2020). In addition, only half of this figure is funded through public budgets. The rest is funded mainly through out-of-pocket (OOP) spending and to a minimal extent through private health insurance.

Sources: Shamah-Levy, et al (2021) and OECD (2022).

The Funsalud proposal found fertile ground in 2000, when the political commitment of a newly elected presidential administration allowed Mexico to shift its health policy aims to reach Universal Health Coverage (UHC), driven by the excessive burden placed on families to access essential health care through out-of-pocket (OOP) expenditures. The 2000 World Health Report flagged the high level of catastrophic expenditure among Mexican families, ranking the country 144th for fairness in financial contributions (World Health Organization 2000). Evidence supporting advocacy efforts included an analysis of catastrophic and impoverishing spending across health conditions and associated interventions needed to deliver targeted financial protection to vulnerable population groups. Access to timely and quality cancer care for children –including medicines– emerged as a flagship set of interventions to be included in the purposely designed Catastrophic Spending Protection Fund (FPGC for its acronym in Spanish). The Ministry of Health (MoH) secured Ministry of Finance (MoF) funding and Congress amended the General Health Law to launch the SP in 2004.[1]

For 16 years – overlapping four presidential administrations, SP provided expanded health access and financial health protection to hitherto uninsured Mexicans. The reform involved a new financial architecture including federal and states' governments contributions to fund the delivery of two health benefits packages (HBPs): one package of 91 essential interventions, covering about 90% of the leading causes of demand in primary care and general hospitalization, and a package of six high-cost/high-specialty interventions clusters (González-Pier E, et al. 2006). Population coverage, and thus incremental funding, was phased-in over a 7-year period. The arrival of a new Presidential administration in late 2018 withdrew political support and SP was repealed the 1st of January 2020. By then, SP was providing coverage to 52 million Mexicans (41% of the total population), the number of essential interventions had increased to 294, and the high-cost interventions grew to 66 comprised in nine broad disease clusters (CNPSS 2019).

This case study aims to illustrate the life cycle of explicit priority setting in health in the context of the Mexican experience. It encompasses more than 30 years of policy progression

[1] Ensure fairness in health financing was one out of five health objectives set in the National Development Plan 2001-2006, which is the guiding document in each Presidential administration, the other ones being to improve the health conditions of Mexicans, reduce health inequalities, guarantee adequate treatment in public and private health services, and strengthen the health system, particularly its public institutions.

starting in the early 1990's when the explicit definition of a set of cost-effective interventions was introduced by the MoH to support the national vaccination campaigns and tackle maternal, new-born and child mortality under a context of highly limited resources up to 2020 when the SP was dismantled alongside the two explicitly defined HBPs. For nearly 30 years, HBPs guided health coverage expansion paths. The story of the rise and fall of HBPs in Mexico provides valuable lessons to other countries at different stages of maturity of HBP design and implementation. Understanding accomplishments and shortfalls of explicit priority setting and the elements of sustainability can help guide efforts for UHC reforms. The benefits of targeted policy to increase access to health services through HBP, particularly through SP, are plenty and have been documented elsewhere (Frenk et al. 2006, Knaul et al. 2012 and 2023). This case study is intended to provide a critical but constructive reflection of the key role of explicit priority setting and HBPs, from a health system and long-term perspectives.

2.0 Priority Setting Process

Health inequalities have long been a concern in Mexico, resulting from disparities in socioeconomic determinants, health financing, and access to quality care in a fragmented healthcare system. This has led to significant disparities in health outcomes, with a nine-year difference in life expectancy at birth between the poorest municipality in the southern state of Guerrero and affluent suburbs of the northern city of Monterrey (CONAPO 2019).

In 2000, health financing disparities translated into an average level of public per capita spending 2.1 times higher for the insured through social security than for the uninsured. Furthermore, federal expenditure per capita across the 32 states was 6.1 times higher in the state with the highest expenditure than in the one with the lowest. Differences in state per capita contributions to health care in the same year were even more dramatic, more than 100 times higher in the state with the highest expenditure than in that with the lowest (Knaul, et al 2012). It is in this context that continuing efforts to increase health care access and reduce health financing gaps across regions and populations have taken place over the last 30 years.

First encounters with explicit priority setting started in the early 1990's, when the MoH led continuing efforts to improve children's health by building upon previously successful universal vaccination campaigns and the use of interventions – notably oral rehydration salts. The result was that a package of highly cost-effective interventions was embedded into national health weeks which took place twice per year and were dedicated to children's health. From this experience emerged the notion that vertical programs could be a first step towards coverage expansion through what is called a diagonal approach (see Box 2).

Box 2. Diagonal approach

The medical published work has long debated which approach to delivering health interventions is more effective: vertical programs or horizontal programs. Vertical programs refer to focused, proactive, disease-specific interventions on a massive scale, whereas horizontal programs refer to more integrated, demand-driven, resource-sharing health services. This situation is a false dilemma, because both

interventions need to coexist in what could be called a diagonal approach, that is, the proactive, supply-driven provision of a set of highly cost-effective interventions that bridge health clinics and homes.

Mexico has a long tradition of prioritizing interventions with great impact on population health. Several public health cost-effective interventions implemented since 1985 explain the rapid declines in child mortality, particularly from diarrheal diseases in infants. Public health interventions packages including a series of cost-effective interventions of expanded immunization vaccine schemes, oral rehydration salts, micronutrients such as vitamin A and zinc, deworming with albendazole, among others. These interventions started as vertical programs and were later scaled-up through National Health Weeks and finally mainstreamed into UHC driven HBPs. This strategy exemplifies the diagonal approach. Such incremental implementation of multiple public-health interventions could be thought of as the equivalent of a public health "polypill".

Source: Sepúlveda, et al (2006).

Later on, in 1996, the notion of an explicit intervention package was revisited by the MoH as part of a Program for Extension of Coverage (*Programa de Ampliación de Cobertura*, PAC). At the time, the MoH had resumed the devolution of health-care provision to the states that had started in 1987 but lost momentum soon thereafter as states pushed back for reasons of budget uncertainty and political considerations. The new conditional transfers to deliver a package of basic services proposed under PAC provided policy incentives to strengthen stewardship in the devolved states. Covering 34 health-care interventions in 13 different categories of community based and preventive personal care, PAC was then adopted as the health component of the internationally recognized poverty alleviation conditional cash transfer program PROGRESA. PAC matured as a centrally managed program, but by 2001 it was evident that 34 covered interventions were insufficient to support the chronically underserved, rural and poor target populations (González-Pier, et al. 2006). (See Box 3).

Box 3. Essential interventions covered by the Program for Extension of Coverage (PAC, by its acronym in Spanish)

PAC deemed essential interventions those that were high-impact, low-cost, technically feasible and aligned to a restricted budget envelope. Within its scope, the package allowed the addition of other services according to regional priorities (for example malaria, onchocerciasis, and dengue). Community-based and preventive interventions, community participation for self-care of health and actions of collective benefit were at the core of this essential package, in addition to health promotion and education and health care interventions. Interventions were grouped in the following 13 categories:

1. Basic sanitation at family level: control of harmful fauna, home water disinfection, sanitary disposal of garbage and excreta, and health education.

2. Family planning: orientation and distribution of contraceptive methods, identification of the population at risk, referral for IUD application, tubal ligation or vasectomy,

cervical-vaginal cytology and infertility management, and education and health promotion.

3. Prenatal care, delivery and postpartum, and newborn care: identification of pregnant women, prenatal consultations, application of tetanus toxoid, iron and folic acid supply, promotion of breastfeeding, identification and referral of women with high-risk pregnancy, family planning counselling, eutocic delivery care, immediate newborn care, screening and referral of the newborn with problems, application of the Sabin and BCG vaccines to the newborn, postpartum care, and health education.

4. Surveillance of child nutrition and growth: identification of children under five years of age, diagnosis and follow-up of the child without malnutrition, follow-up of the child with malnutrition, nutritional diagnosis, nutritional guidance, referral and counter referral, training for mothers, micronutrient delivery, health education.

5. Immunizations: vaccine administration, and health promotion and education.

6. Case management of diarrhea at home: education and training for mothers, treatment of cases, distribution and use of rehydration serum sachets, referral of complicated cases, and health education.

7. Antiparasitic treatment for families: periodic administration of antiparasitics to the family, and health education.

8. Management of acute respiratory infections: training for mothers, specific treatment, referral for treatment, and health education.

9. Prevention and control of pulmonary tuberculosis: identification of coughers, primary treatment, study of contacts and protection measures, reinforced treatment, and health education.

10. Prevention and control of arterial hypertension and diabetes mellitus: detection, diagnosis, treatment and control of arterial hypertension; screening, diagnosis, treatment and control of diabetes mellitus; and health education in arterial hypertension and diabetes mellitus.

11. Accident prevention and initial injury management: first aid in case of wounds, burns, dislocations, unexposed fractures, open fractures, poisonings; case referral, and health education and promotion.

12. Community training for health self-care: promotion of social participation, support for health campaigns, protection of water supply sources, social participation in the production and use of food for self-consumption, in health care and service utilization; and health education.

13. Prevention and detection of cervical-uterine cancer: identification of population at risk, timely detection, follow-up of results, diagnosis and referral for treatment to the

second and third levels of care, as appropriate; monitoring and control, and health education.

Source: Secretaría de Salud (2000).

The introduction of SP in 2003 built on Funsalud's 1994 reform proposals and WHO evidence of Mexico's poor performance in financial protection. Funsalud's costed package of essential interventions extended previous ones and aligned cost-effective interventions with the leading causes of demand for health care services, mainly in primary care and general hospitalization settings.

Presidential political commitment was crucial in proposing a reform of the General Health Law to Congress in 2003. In 2000, for the first time in 70 years, a democratically elected President from an opposition party took office, allowing for the opportunity to translate the democratic principles of inclusiveness, equity and citizenship-based rights into health reform. Along this line, SP aimed to level the financial contributions and access to health care interventions across population groups, ensuring that access to health care depends on citizenship and not on employment status.

The introduction of HBPs under SP involved building on previous HBPs experience and a series of additional preparatory analysis undertaken by the MoH. This included an in-depth analysis of supply-driven delivery of health interventions supported by line-item budget allocations both at the federal and state level, and the learnings of a pilot program in five states. The pilot helped to refine the essential interventions package and secure buy-in from other states, informing discussions with the MoF and congressmembers. While negotiating the reform in Congress and with states' governors, political commitment was obtained by linking additional funding to the responsibility for enrolling the target population and delivering interventions covered in both packages.

SP aimed at covering the uninsured 50 percent of the Mexican population (who had no access to social security). During a 7-year roll out period, population coverage was to be increased gradually alongside additional financial resources. Enrolment went up from 5.3 million in 2004 to 51.8 million in 2011, or 45 percent of the total population at the time. Over the following years, annual enrolment remained above 50 million reaching a maximum of 57.3 million in 2014 (CNPSS 2019).

The SP had a financial tripartite scheme set into law, which included contributions from the federal and state governments, and to a lesser extent from beneficiaries. All budgetary allocations to states were based on enrolled families according to pre-negotiated rollout targets. To improve financial equity, the federal government would support the scheme with the same per family contribution it had been allocating to the population covered under IMSS. Using local revenues, states were required to contribute with a smaller per capita allocation in exchange for matching funds from the federal MoH that were adjusted based on a formula that took into consideration health needs among other criteria. In theory, families would be charged a small means-tested co-insurance premium. Families from the poorest three income deciles were exempt, and in practice most SP beneficiaries did not pay into the system. Although allocations were initially set according to affiliated families, rules were modified in 2010 partly resulting from strategic gaming from some states who had room for

modifying the way in which families were accounted for.[2] In 2010, funding rules were re-defined on a per person basis to increase transparency and accountability (Knaul, et al. 2012).

SP beneficiaries automatically had access to the coverage of two supplementary HBPs: the Universal Catalogue of Essential Interventions (*Catálogo Universal de Intervenciones Esenciales en Salud*, CAUSES) and the interventions covered through the Catastrophic Spending Protection Fund (*Fondo de Protección para Gastos Catastróficos*, FPGC). The funding source of CAUSES came from the combined federal and state per capita allocations, except for an 8 percent share that was kept at the central level to fund the FPGC. Financial rules and content revision of both packages were done through separate processes. These responsibilities fell under the SP National Commission (*Comisión Nacional de Protección Social en Salud*, CNPSS) run by the federal MoH who oversaw the SP in coordination with the 32 states.

Both CAUSES and FPGC packages covered personal health care interventions but followed different criteria for priority setting and processes for inclusion and revisability mechanisms. CAUSES' guiding principles to include interventions followed mostly health maximizing criteria informed by burden of disease and cost-effectiveness considerations with a resulting focus on primary care and general hospitalization; whereas the FPGC focused on high-cost or high-specialty interventions exposing families to financial hardship but followed less technically strict considerations and was prone to pressures from a mix of political actors, social organizations, health professionals and industry associations, yet it was kept in check by hard financial feasibility constraints informed by actuarial studies. Both processes were supported by technical work including costing, budget impact or full health technology assessments, developed by internal teams comprising budget officials and health system experts or external technical advisors, and decisions were made and sanctioned by collegiate bodies within the MoH. Finally, it is worth noting that although both HPB's packages largely guided service delivery of state health care networks and federal hospitals, a considerable yet unquantified volume of care fell outside the scope of the explicitly defined benefit packages, thus reflecting the fact that in practice, service providers are faced with the need to respond to pressures not accounted for in HBPs, such as the need to continue providing care available before packages were in place, services provided to promote medical training or those justified under a research protocol.

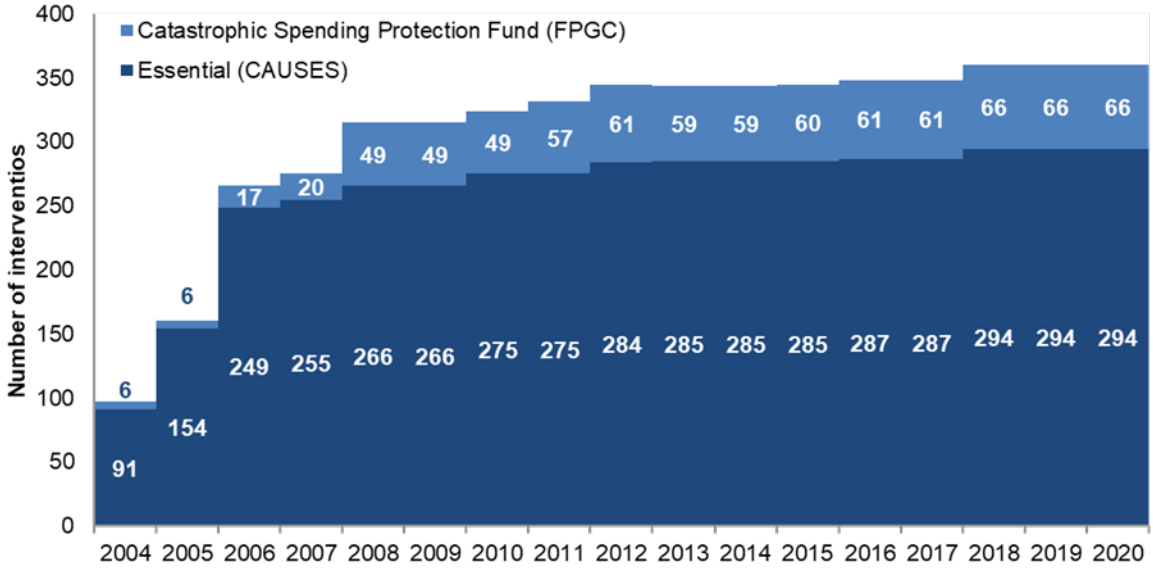
During the pilot program a basic package of 78 interventions that aligned essential interventions covered earlier through PAC and PROGRESA and integrated other vertical programs federally run, was costed and implemented. This initial pilot package was the basis for the definition and costing of CAUSES.[3] Eventually, 294 interventions were included in CAUSES (see Figure 17.1). These covered most causes of demand in primary care and nearly 95% of all causes of admissions in general hospitals (Knaul, et al 2012; González-Pier, et al

[2] States had incentives to register individuals 18 years and above living in the same household as single-person family units. The other argument related to the need to have more accurate enrolment targets. Family size was estimated using a national average which showed variations across states.

[3] This package included interventions addressing specific diseases and/or population groups in the following service categories: preventive medicine (immunizations and detection, medical, psychological, diet and exercise counseling services); outpatient consultations (family medicine, community mental health services, reproductive health services); and urgent care, hospitalization and surgical services, including pregnancy, childbirth and newborn care).

2006).[4] State health services were responsible for the direct delivery of CAUSES to the population enrolled in SP. Interventions included in CAUSES were relatively low cost and high volume, and the financial risk associated with budget holding could be diversified at the state level. In contrast, FPGC's focus was to provide financial protection through the coverage of high-cost/high-specialty care interventions. These included some health conditions of low incidence but high financial risk. FPGC resources were retained and managed at the federal level to reimburse providers on a per case basis. The underlying rationale was to diversify the financial risk at the national level.

Figure 1. Evolution of HBPs in the context of SP



Source: Authors' adaptation based on Knaul, et al. (2012) and CNPSS annual reports.

FPGC exemplifies the budget and delivery challenges countries face when expanding interventions beyond essential services. Launched in 2004 with six conditions, (cervical/uterine cancer; acute lymphoblastic leukemia; prematurity, neonatal sepsis, respiratory distress syndrome; and ambulatory antiretroviral therapy), political pressure led to the inclusion of 66 conditions by 2019. In practice, the FPGC having accumulated significant reserves over the initial implementation phase became the main mechanism through which demands for coverage were channeled. This dynamic generated explicit choices and budget impact analysis in a more orderly fashion. Yet, how effective the inclusion process balanced political and technical arguments is still debatable. Some interventions have been included based on the political pressure -in some cases successfully led by organized patient groups and on inclusiveness grounds- whereas others have relied more on the technical arguments, including financial protection both from the individuals and public institutions' perspectives (CNPSS 2019; Lozano and Garrido 2015).

[4] Interventions reflected a combination of diseases covered and specific population groups as well as preventive and community health interventions.

In some cases, covered interventions have legitimately and successfully increased financial protection. This is the case with various oncology treatments, including children's cancers. In other cases, the way to balance the inclusion demands with financial resources has resulted in age limits that contain the financial risk from the public institutions' perspective but are hard to explain to society, especially when illnesses may affect individuals throughout their lives. This is the case with kidney transplants. For years, pressure to include hemodialysis and end-stage renal disease coverage for the uninsured kept mounting without a clear decision being made. At 16.8% of adults, Mexico's prevalence of diabetes is one of the largest in the world (Basto-Abreu, et al. 2021). Given the poor rates of controlled diabetic patients, chronic renal disease is one of the leading causes of mortality among Mexicans. However, had replacement therapy for end stage renal disease been covered without limits, significant crowding out effects for other interventions would have taken place since no additional funding was anticipated for SP. Thus, discussions mostly centered on the age threshold and criteria to cover renal transplant. In 2011, the intervention was finally included but only for individuals under 18 years old (CNPSS 2019; Lozano and Garrido 2015).

Another example is hemophilia, whose treatment coverage was also included in the FPGC in 2011, but only for children under 10 years old. This was a positive result for a demand that had been in the agenda for a long time but the way it was defined also created concerns in terms of continuity of care for a lifelong disease, in addition to patients in need whose age is above the threshold.

Both CAUSES and FPGC catalogues remained separate from the provision of public health goods (such as epidemiological surveillance and vector control) and community-based and intersectoral interventions to tackle behavioral risk factors. Although the SP reform included a provision to create a specific fund to protect budgets for non-personal interventions from pressures to redistribute additional funding to personal interventions, the Fund was never created. These continue to be funded and managed centrally as vertical programs and was delivered locally in parallel to the SP.

3.0 HBP Implementation: Challenges and Repeal Process

The SP had significant achievements in terms of increased coverage and access to health care as well as financial protection for its target population, as documented by Knaul et al (2023), yet by 2019 it also faced a series of challenges beyond those outlined in this section which focus on the implementation of HBPs. Some of those challenges would have merited further policy adjustments or a subsequent reform, especially to consolidate or extrapolate some of the SP results to the overall health system. For example, despite increased coverage and budget allocations to fund the implementation and expansion of SP during its early years, public health spending's share of GDP remained almost equal to the private health spending's share since 2016 and until the COVID-19 pandemic (OECD 2022). In addition, resource pooling for catastrophic interventions was not expanded to the rest of the health system, and mechanisms to enable the cross-delivery between public health care providers had not been fully and effectively put in place; furthermore, no major steps had been made to explore improvements in resource allocation within the states or to fully incentivize quality assurance through provider payments.

In terms of the challenges related to the implementation of HPBs under SP, these can be framed into three distinct phases. An initial phase relates to the launch of the HBPs where clinics and hospitals race to deliver the mix of interventions initially listed in the packages. A second phase follows as HBPs mature and new interventions get added without a clear alignment with budgetary space or the human resources needed to deliver more complex and costly interventions. A more recent third phase took place when political and social pressure mounted around a set of excluded interventions that could not be added without significant additional resources and cannot be technically justified on the grounds of value for money or significant reductions on the burden of disease. In 2020, by repealing the SP through a Congress reform, the government reverted to implicit rationing of health services allowing for less transparency in coverage decisions and more discretionally defined budget allocations to promote political and electoral benefits.

The initial offer of the CAUSES and FPGC involved a mix of three types of health interventions. A first group of interventions that where already fully offered at the time SP was launched – examples include antenatal care, HIV services, hypertension and diabetes screening and basic surgery. The initial HBPs simply recognized these interventions as part of the package allowing for a quick acknowledgement of available coverage. A second group consisted of interventions that, while offered, still showed considerable gaps across the continuum of care or inequitable access across geographies. The response was expedient and concentrated on improving the supply of pharmaceuticals, medical devices and paying for extra time to staff already hired. A third group comprised new interventions which required high technology equipment which was not only more expensive to purchase but challenged existing supply chain logistics and required highly trained personnel to operate. Sufficient human resources for health in the form of specialized physicians, nurses and technicians was the single most important bottleneck to translate packages into service delivery. Moreover, the supply response lags across health inputs – for example, the timely purchase of drugs and imagining equipment was ineffective without the trained personnel to adequately prescribe or correctly interpret a mammograph. Poor coordination of care delivery was particularly acute in rural and underserved areas.

As delivery catches up with the scope of HBP a second phase comes in where new interventions get proposed and accepted into the HBPs without the corresponding adjustment in available budgets. The financial rules of SP where fixed by law including per capita allocations to deliver the CAUSES and funds used to reimbursed directly to certified providers on a cost per case basis in the FPGC. Only inflation was used to update annual budget allocations. States' total budgets were set in line with the population enrolled. Inertial additions to both packages fueled by political and social pressures had to either be funded with additional enrolment targets or technical efficiencies in service delivery. As the system matured it became increasingly difficult to sustain package expansion; reforming again the health law to mobilize additional resources faced sustained opposition from the MoF due to limited fiscal space.

Finally, a third phase relates to the case when relatively comprehensive HBPs lose momentum because of lack of new funds and an insufficient longer term supply response. HBP dynamics shifted from what to include to how to keep new interventions from being included. A focus on exclusions is politically less palatable and raises concerns of inequality

and discrimination. It was also vulnerable to critique for failing to exercise the constitutional human right to health protection enshrined in the Mexican constitution in 1983. Along populist lines, the new administration attacked SP and its concomitant HBPs as the main obstacle to comprehensive health care for all. SP was repealed and purportedly replaced in January 2020 with the National Institute of Health for Wellbeing without any clear financial and operational rules or a detailed workplan on how to fulfil its mandate of unfettered UHC. A final challenge is thus related to sheltering HBPs from becoming politized and captured by populist ideology. Dismantling HBPs disempowers citizens, reduces transparency and accountability, and makes the health sector prone to serve political and electoral agendas.

4.0 Limitations and Future Directions

Over the past 30 years HBPs have not achieved their full potential as the cornerstone to UHC in Mexico. Limitations can be organized across the three subfunctions of health financing: resource mobilization, pooling and purchasing.

HBP expansion lost momentum when the pressure to include new interventions was not matched by increased budget appropriations to fund additional coverage. HBPs have the capacity to change the narrative when advocating for new resources. Congressmembers, civil society organizations and government officials can more easily relate to the health sector if resource needs are framed in terms of health conditions and interventions needed to tackle them instead of line budget items. This did not happen. Fiscal space for health could had improved if the benefits of excise taxes on sugar sweetened beverages, tobacco, alcohol or other products deemed harmful for health had been linked to the cost of delivering a set of interventions explicitly listed in the HBP. In fact, new revenues could had been more easily earmarked for health under a properly communicated and functional HBP. This was a missed opportunity to mobilize resources.

HBPs greatly improved equity of access at the subnational level only within SP but failed improve pooling and equity of access across national subsystems. The HBPs was not adopted by the other main health insurance schemes, most notably social health insurance institutions and private health care plans. In particular, the FPGC was a missed opportunity to pool resources to fund risks for expensive health conditions that can be better diversified at the national level across the entire health system.

HBP failed to make additional improvements to increase value for money. The HBP remained mostly concentrated in facility based (medical) interventions with no additions into community-based activities and intersectoral policies. Both packages had limited influence to guide long term resource generation strategies, basically infrastructure plans and training programs for health professionals. Quality and responsiveness elements of health care were not integrated to the BHP and quality assurance efforts were often disconnected from the priority setting line of work.

5.0 Lessons Learned and Opportunity Areas Identified for Future Analysis

HBPs support country specific pathways to achieve UHC by introducing an ordered way to decide and legitimize decisions on which interventions should be covered and for whom. Such decisions also require supporting information and evidence, transparent and rules-based deliberation mechanisms in place, standards of practice and evaluation. Thus, HBPs are conducive to the development of accompanying information-based tools and decision processes, as well as regulations and policies supporting the health system to improve responsive and quality care needed to move forward in the chosen UHC pathway. Implementing a HBP also has implications in terms of guiding a human resource formation strategy that are adequately planned and funded.

The relevance and role of a HBP depends on which phase the country is in its path to UHC. A country might choose to transition from positive lists that seek to promote access to negative lists that serve the role of gatekeeping to maintain value for money, allocative efficiency and sometimes limit abusive use of scarce resources. In general, HBP transitions are largely influenced by stage of HBP implementation and health financing maturity, both in terms of sufficiency and sustainability of HBPs.

In the case of Mexico, dismantling a HBP-based funding scheme after 16 years of implementation entails the loss of a pivotal element to guide the decision-making process leading towards UHC. Eliminating HBPs will most likely not affect services operation in the short term, especially of primary care and general hospitalization interventions which mostly follow an inertial logic as long as budgets are maintained. What could be missing is a set of rules and a convening platform to discuss the new technologies and interventions to be covered with additional resources. The latter has deeper implications for high-cost more complex interventions that had been guided and funded by the FPGC.

Just as we analyze the health system performance benefits derived from HBP implementation, the Mexican experience will generate a natural experiment to understand and document the effects of eliminating HBPs. The evolution along the following three elements that link HBPs with health system performance are to be closely watched in the coming years:

1. **The role of HBPs in protecting health budgets and facilitating additional allocations.** HBP packages help bridge the gap between ministries of health advocating for increased funding and ministries of finance and other stakeholders defining fiscal space for health. Discussing health budgets in terms of health interventions, population benefiting from improved coverage and measurable access targets should resonate with Congress members in charge of the budget appropriation process and MoF officials charged with drafting the initial budget proposals and release of allocated budgets. In the absence of CAUSES and FPGC budget allocation to specific health areas should be affected in directions that remain to be seen.

2. **The weakening of MoH stewardship tools that operate in conjunction within HBPs.** HBP implementation tends to be accompanied by a series of measures and tools that feed

and are reinforced by HBPs. These include a drug and devices formulary partly guided by HTA, the requirement to provide a need certification to authorize large investments in medical equipment, clinical protocols and practice guidelines, medical continuous education and specialists training, and resource allocation rules. With HBP being dismantled these elements might be affected or replaced.

3. **UHC sustainability through HBP induced patient engagement and empowerment.** Without an explicit HBP there should be a loss of accountability and reduced empowerment of citizens to demand rights and access to specific interventions. Not setting explicit limits based on an agreed set of interventions might revert to rationing of services which tends to not only be less efficient but also inequitable, as better-off populations and geographies tend to have more voice and political influence to leverage health resources in their favor. The absence of HBPs can thus be conducive to a less vocal and engaged constituency of UHC reforms. Finally, changes in UHC performance indicators, in terms of population coverage, access to quality services and degree of financial protection should reflect the regime shift away from BHPs (see Box 4). The jury is out.

Box 4. Replacement model and early evidence on its effect

SP was formally repealed as of January 2020, just as the COVID-19 was entering the scene. The SP was replaced by the National Institute of Health for Wellbeing (INSABI, by its acronym in Spanish), with the intention to centralize resources and functions previously undertaken by the states to provide health services for the population without social security. Under the new scheme, previous rules defining federal and state budget allocations were eliminated alongside HPBs. The budget is now to be defined annually through the federal government budgeting process and in principle, should not be less than the amount allocated in the previous year. In practice, this has meant for the states having to negotiate again with the federal government through INSABI and the Ministry of Finance their annual budgets. With a government facing the pandemic pressure, no secondary rulings were immediately enacted to detail further specifics of the new model to replace SP. Concomitantly, under IMSS political leadership a new proposal emerged to use IMSS-Bienestar as a platform to negotiate with the states the centralization of their financial, human, and physical resources. In 2022, IMSS-Bienestar was granted an arms-length status to run services for the population without social security in those states that signed a centralization agreement. IMSS-Bienestar is a program that provides basic primary and secondary care services to 11.6 million people who live in marginalized urban and rural areas through its own facilities. The program is funded by the federal government and is run by IMSS in parallel to the IMSS' social security medical benefits service platform. At present, 18 states have signed such agreements, and IMSS-Bienestar will replace INSABI as responsible for providing services for the population without access to social security, also including the centralized procurement of health inputs and the management of the FPGC, which has been maintained but renamed as Wellness Health Fund and financed through resources retained from budget allocations of states who have signed an agreement with IMSS Bienestar.

An interesting fact is that the dismantling of SP did not result in a widespread rejection from SP beneficiaries. Notwithstanding the rejection to the reform from opposition political parties, the reforms were approved without a massive major reaction from

citizens. The main reaction from ex-SP beneficiaries to recent policies changes, has come mainly through demonstrations by families of children with cancer due to a widespread lack of medicines resulting from the dismantling of the previously existing procurement process. This is relevant since it indicates that the entitlement and citizen's empowerment intended to be promoted through SP and HPBs did not permeate enough in SP beneficiaries.

In terms of evidence of the effect of replacing SP, so far, this is scarce since no formal evaluation has been made to render the new scheme accountable. Yet, some early results can be drawn from national surveys in terms of coverage and financial protection. It is worth noting that some of these results may reflect a combined effect of dismantling SP and the COVID-19 pandemic, as well as some challenging trends observed in the late years of SP.

1) Coverage
   The share of the population without access to health services (based on self-reported affiliation or explicit coverage from a public or private institution) increased from 16.2% (20.1 million) to 39.1% (50.4 million) between 2018 and 2022.

2) Financial protection
   The share of households facing catastrophic expenditures (at a 30% threshold of households' disposable income) between 2016 and 2020, showed a slight reduction from 2016 to 2018 (from 2.82% to 2.76%), and a significant increase from 2018 to 2020 (from 2.76% to 3.90%) according to a recent World Bank study on health financing sustainability and resilience in Mexico. This trend is consistent with recently published estimates by Knaul et al (2023) which show in addition that excessive spending (i.e., catastrophic or impoverishing expenditures) more than doubled for the uninsured compared with those with social security between 2018 and 2020.

Sources: CONEVAL 2023, IMSS Bienestar 2022, IMSS 2023, Knaul et al 2023, Presidencia de la República 2022 and 2023, World Bank 2023b.

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