

CHAPTER 5

MEXICAN INSTITUTE OF SOCIAL SECURITY

5.1. THE NATIONAL HEALTH SYSTEM IN MEXICO

This is a mixture between the public and private sectors. Public institutions are the Ministry of Health (SSA), Institute of Social Services and Security for Civil Servants (ISSSTE), Social Security for Oil Workers (Pemex), Social Security for Army Forces, Social Security for Navy Forces, Department of Federal District (DDF), individual State Services, and the Mexican Institute of Social Security (IMSS).

Table 5.1 shows the distribution of the Mexican population by institution in 1995 and 1996.¹⁵⁹ IMSS covers 41% of the total population and the Ministry of Health (SSA) a further 30%. This distribution could vary in reality since people could have been reported as being in several organisations as members of different types of health insurance schemes. Some figures are, therefore estimates of the potential population.

Table 5.1
Distribution of the Mexican population by institution in 1995 and 1996

<i>Institution</i>	<i>1995</i>		<i>1996</i>	
	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>
IMSS (Ordinary)	34,323,844	37.65	37,260,957	40.87
ISSSTE	9,246,265	10.14	9,311,540	10.21
Pemex	518,552	0.56	539,521	0.59
Army Forces	315,550	0.35	361,344	0.40
Navy Forces	216,310	0.24	182,228	0.20
States Services	1,103,319	1.21	1,157,617	1.27
DDF	3,681,018	4.04	3,698,740	4.06
IMSS-Solidarity	10,540,050	11.56	11,038,703	12.10
SSA (potential)	31,213,381	34.24	27,609,912	30.30
TOTAL	91,158,290	100.00	91,160,562	100.00

The private sector has only a small population depending on the payment capacity of the population. It is known that the private sector has nearly 7% of the total number of medical units, 26% of the beds, 15% of physicians, and 13% of the consulting rooms. However, only just over 1% of the total medical encounters occurred there. It is important to mention that a high proportion of physicians in the private sector also have duties in and are employed by the public sector.

It has been reported^{160,161} that the quality of care within the private sector is lower than in the public facilities, especially in single consulting room facilities and small hospitals, which are the majority, with 90% of the private facilities having 24 beds or less and 79% had 14 or less in 1996.¹⁶² There is no official information about participation in private insurance but it has been reported to be lower than the proportion utilising private health sector. Private services are mainly paid for directly by the health service users.

5.2. HEALTH SECTOR REFORMS

Health Sector Reforms in Mexico,¹⁶³ as in many other countries, was explicitly established in 1995. Proposals were: a) to reduce the proportion of uninsured Mexican population; b) promote organisational decentralisation; c) increase provision of a basic package of services for all the population; and d) encourage the private sector to become more involved in the financing and delivery of services. Some strategies have been established since its introduction. However, some of them have not found political and social acceptance and are under discussion in the public policy arena. Current conditions are summarised in the following paragraphs:

1. The Mexican's Health System has been partially decentralised, but central government participation in each field and state is apparent in programmes and budgets.
2. Economic support has been provided to IMSS so that it can increase the population covered by the institution under new forms of family insurance.
3. The basic package of services (immunisations, family planning and oral

re-hydration) has reached almost the whole population, although for some remote rural areas access has yet to be provided.

4. The Ministry of Health retains control of the general public health programmes and the delivery of some services in its medical units. Other health institutions are regulated only partially, since they are social security institutions with their own legislation and have the same status as the Ministry in the Mexican Government's structure.
5. The financing scheme is different in each institution, depending on the protected population. Social security schemes are financed by workers (industry and services workers, oil workers, civil servants, army forces, navy forces) and by the government, with IMSS also receiving contributions from employers. Other institutions are financed directly through taxation by the government.
6. The delivery of services is organised by level of care (two or three levels) in each institution and some of them in a regionalised form, working through the referral system.
7. There are recognised problems with the quality of care, especially when resources are scarce and there are increasing needs (demographic and epidemiological change), reductions in budgets (economic crises), and demands surpass the available supply. However, IMSS has been recognised as the best institution in providing services and for its attempts to improve quality of care and programmes. Other institutions have tried to establish similar programmes based on IMSS experience.
8. In order to rationalise decision making in the national health system, estimates have been made of the cost-effectiveness of some interventions and the number of years lived without disability. The burden of diseases in Mexico was thus established and the priorities were defined. However, political and social conditions have not been propitious and policies have not been entirely accepted at the national level.
9. A main issue in the Mexican health system is how to promote equity within the financing and delivery of services. It is well known that some

groups of population are receiving more and better services through social security systems and yet the poorest have more health needs and less access to health services. The IMSS-Solidarity system is one of the main attempts to reduce the inequity in the distribution of services. Although it has been successful at providing services in the distant and rural areas in Mexico, it has not been enough. The population's health needs not only depend on the availability of sufficient resources but also on whether the cultural, economic, and geographical barriers to accessing services are removed.

5.3. REFORMS OF IMSS

IMSS, considered by some authors as the central player in the Mexican Health System,¹⁶⁴ is a prepaid compulsory social insurance system for workers and their families, financed by the government, employers and employees. The Institute has covered the delivery of services and financing by insurance since its creation by Presidential Order in 1943. IMSS, philosophically created to protect workers against any losses in salary, has tried to cover all possible risks due to illnesses, maternity, job accidents and diseases, disability, old age, death and un-employment in later life (60 to 64 years old).¹⁶⁵

Recently the Mexican government, based on its strategies for health sector reform has been made proposals for more participation of the private sector either in the delivery of services or in the financing of the insurance. However, after demonstrations by groups of organised workers, the General Directorate decided to keep the financing and delivery of services systems publicly managed.¹⁶⁶

Reforms in IMSS and the proposed strategies (1996-2000) have the same philosophical content as when it was created in 1943, but at the same time the economic viability of the Institute is being examined.¹⁶⁷ New IMSS legislation came into force in 1997, with the most important change being in the IMSS policy for pensions. It had the aim of improving the pension system, reducing risks and increasing savings. The strategy was to split the financing system into pensions and health, allowing for public pensions to become more private with a broader participation of national and international investors.

The main proposals in the 1997 legislation for health matters were to: a) increase the proportion of the insured Mexican population as an instrument

of social justice; b) increase financial viability; c) improve the service to satisfy health needs, population demands and expectations with the possibility of retaining fees in the future for private services; and finally d) succeed in cost containment policy by providing services more efficiently and effectively.¹⁶⁷

The new model for “Family Medicine” proposes to re-organise the delivery of services in order to enable them to work more efficiently and to promote an attractive plan for the recruitment of new subscribers (informal sector or non-workers). New strategies are: a) Primary health care will be delivered by an integrated health team of nurses, physicians, and social workers and with medical doctors “on call” and paid by a capitation system); b) patients will be able to select the health team of their preference; c) treatment for the main causes will be standardised and teams will be trained appropriately and d) quality of care will be assured through continuous education and medical research. This model is in the pilot stage and will be implemented more widely after proving it can deliver successful results.

This new family medicine model has some restrictions in coverage for chronic diseases that were not observed before, including no services for diseases diagnosed before getting the insurance. This measure has the objective of protecting IMSS from financial problems due to demands for illnesses which were present prior to join that were observed in the past.

5.4. TYPES OF IMSS INSURANCE

There are different types of insurance: The main type is the compulsory system to protect workers and their families (spouse, children until 16 years old and parents) with health services, protecting salary when workers are sick or on maternity leave (women only), and with social services. The second type is for pensioners and protects ex-workers who made payments during their working life. Workers are entitled to receive the pension when they become 60 and 65 or when they are no longer able to work because of an accident or disease; widow(er)s or orphan(s) (less than 16 years old or more if they are mentally or physically disabled or are full time students) are entitled to receive the pension when the worker dies. This type of insurance also covers the family and includes health and social services. The third type is the voluntary continuation of the compulsory system. When workers have not com-

pleted the required period for entitlement to receive the pension (age or number of contributions), they can continue paying until they fulfil the requirements.

They are also protected with all the services. In the fourth type, the voluntary system, people pay directly and in advance in order to receive health services only. There is only one level of payment for all groups in the population. Recently (1998) the new type of voluntary insurance mentioned above was introduced, the family insurance for non-workers who want their health to be protected by IMSS. This type of insurance is particularly important to those working in the informal sector.

5.5. ORGANISATION OF IMSS

IMSS covers 41% (over 37 million people) of the Mexican population under the ordinary system at the national level.^h It is organised in “Delegations”, which are almost equivalent to the Mexican States but with some differences: The DF is divided in four delegations; the State of Mexico and Veracruz are both divided in two delegations. It means that in Mexico there are 31 states and the DF but in IMSS there are 37 delegations. Each delegation is semiautonomous with regional and central divisional dependence. The headquarters structure is copied at the delegation level, which means that each central division has its equivalent in the delegation in order to follow the same programmes, strategies and activities at the national level.

There are seven regional divisions and each one covers a different number of delegations (North, West, Northwest, La Raza, Siglo XXI, Southeast, and East). The head of the Region is located in the same place as the Medical Center, in order to provide regionalised medical and administrative services.

IMSS provides multiple social and health services for the insured population and some others for the non-insured population through IMSS-Solidarity Program.

The head of IMSS is the General Directorate who is selected by the President of Mexico. The next level is divided into ten normative divisions: Medical Care Benefits, Social and Economic Benefits, Administrative Ser-

^h The IMSS-Solidarity System for non-insured population covers 12.1% additionally. This system is paid by the government through taxes but it is administered and delivered by IMSS.

vices, Affiliation and Collection, Juridical, Finances, General Co-ordination of Orientation and Attention for the Covered Population, General Co-ordination of Social Communication, General Secretary, Internal Comptroller and the General Co-ordination of data processing.

5.6. IMSS INSURANCE BENEFITS

Economic benefits aim to protect at the optimal level the economic survival of workers, pensioners and their families. IMSS provides money according to the specific type of insurance coverage: a) salary for workers who are sick or have suffered an accident or for women before or after delivery; b) pensions for retired or spouses or workers who are not able to work after suffering an accident or job disease or a general disease; and finally c) pensions for spouses or children of the workers who die because of an accident or disease at work.

Social benefits of insurance have the objective of improving the social well-being and the quality of life, so as to prevent diseases. Available services are: a) physical activities in IMSS Sports Centres; b) social activities (meetings, parties, self-help groups, games, etc.) in the Social Security Centres; c) holidays at IMSS Vacation Centres; d) education and training in IMSS Training Centres, Social Security Centres and Handicraft Centres; e) shopping with saving costs in IMSS Shopping Centres; f) free nursery for worker's children at IMSS Nurseries; and g) low cost funeral services (IMSS Funeral Centres). There are special services for pensioners and people 60 years or older in all the centres available at the national level.

5.7. IMSS MEDICAL CARE AND HEALTH BENEFITS

The Division of Medical Benefits is divided into seven general co-ordinations: 1. Community Health, 2. Reproductive and Maternal and Child Health, 3. Occupational Health, 4. Medical Care, 5. Medical Education, 6. Medical Research, and 7. Planning and Medical Infrastructure. Each co-ordination establishes its own plans, strategies and programmes but follows the general policy of the Medical Benefits Director. Some co-ordinations are focused on specific populations (reproductive and maternal and child or job health); oth-

ers in specific actions (education or research) and others have a broad approach to solve the health needs of the covered population (medical care or community health). The objective is to guarantee the human right of being healthy and to provide health services for the covered population.¹⁶⁷ In order to fulfil its responsibilities, the general process of medical care includes: health promotion; medical care for those who lose their health; education and training of the new generation of health service providers; and development and diffusion of new knowledge through research and development.

Medical care is provided in a regionalised structure and by levels of care. The first level is provided in the FMU (there are about 1500 at the National level). It is considered that 85% of the population's health needs have to be solved with the resources at this level. Each unit has a laboratory, x-ray services, family planning services, preventive medicine, social work, and dental services, in addition to the medical services provided by family medicine specialists (13,503 physicians). During 1996, 65.6 million medical consultations were provided in the first level, averaging over 273,000 per day.

The second level of care is provided in General Hospitals (HGZ). There are 215 HGZs in the country and these provide hospitalisation in four basic specialities (paediatrics, gynaecology and obstetrics, internal medicine, and general surgery) and medical care in the main medical specialities. They have the same additional facilities as the FMUs and others, like the emergency and labour services in each one (there are emergency services in some family medicine units). It is established that 12% of the population have to solve their health problems in this level.

The third level of care is provided in the larger and specialised hospitals in the medical centres (CMN). There are 10 CMNs located in the main cities in Mexico and 41 hospitals within them. There are physicians in each speciality and sub-speciality to provide hospitalised medical care or external consultations. According to the care norms, 3% of the population's health needs have to be solved at this level.

Adding together the medical encounters of patients in HGZs and CMNs, over 14.6 million consultations were received by the population covered by IMSS in 1996, averaging over 61,000 every day. Services provided in emergency rooms in 1996 were 12.5 million consultations, an average of 52,000 every day. Finally, there are about 1.6 million hospital admissions in a year.

In 1997, nearly 1600 physicians were trained in one of the 55 branches of medical specialisation, and over 1600 in 1998.ⁱ Medical doctors trained in IMSS are later contracted by other public and private institutions in Mexico and other Latin American countries.

The current model is disease oriented¹⁶⁸ and provides services by demand or programme. Reforms within IMSS propose to develop a prevention oriented model, strengthening the first level of care in order to provide high quality health care that also considers social, psychological and physical factors affecting the individual and family life within the community. There are some economic constraints, which affects directly the delivery of and the quality of services. The cost containment programme has been established since 1994. However, it is considered that the investment in preventive actions and the more efficient use of the scarce resources will result in more health benefits.

5.8. SUMMARY

1. IMSS is considered to be a health and social security institution, financed by taxation and contributions, that delivers health, economic and social services. It covers over 40% of the Mexican Population under the ordinary scheme.
2. It is recognised as the main and best public provider of health services in Mexico.
3. The medical care is delivered in three levels of care and in a regionalised way.
4. There are some attempts to improve the efficiency through the cost containment programme established in 1994 but it does not include actions of rationing of care by population, diseases or programmes. The political cost of these programmes is difficult to assess as the structural adjustment economic programme is affecting the Mexican society. IMSS is well known as one of the buffers for the social instability in Mexico.

ⁱ This information was provided by the Co-ordination of Medical Education. IMSS, 1998.

5. It is the biggest national institution for the training and education of physicians in Mexico, who later work for the private and public sectors.
6. IMSS is in the forefront of medical research (biomedical, clinical and in public health) with more scientific production than some national institutions that focus only on research.