X

Social Security in Mexico

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The purpose of this chapter is to present a quantitative-qualitative panorama of social security in Mexico during the nineties. This was a crucial period for social security and particularly for the Mexican Institute of Social Security (Instituto Mexicano del Seguro Social / IMSS), the hegemonic body of institutionalized social welfare. We also aim to evaluate the transformations carried out in all the insurance branches, especially the changes introduced through the reform to the insurance laws in 1995 regarding retirement. The core idea underlying this chapter is that this reform is the cornerstone in the restructuring that dissolved the notion of social security in Mexico.

This chapter is structured into four parts. The first part remits to the most important background aspects of social security policy in Mexico, such as its stages of development, the main reforms to the law, the evolution in its coverage, financing, branches of insurance and its most important chronic problems. The second part focuses on the nineties and analyzes the evolution of the IMSS. It includes multiple statistics regarding affiliation, membership, global coverage, incomes and expenditures, elusion and moratoria, tripartite contributions, etc. The third part contains a concise evaluation of pensions and health care services since the 1995 reform and in the last part we approach issues regarding persisting problems and we present our conclusions.

MILESTONES IN THE HISTORY OF THE SOCIAL SECURITY POLICY IN MEXICO

Social security policy in Mexico was unified and institutionalized in 1943, the year the IMSS was founded. Before then, social security services were provided by private companies and there were different local and national public institutions that administrated both civil and military pensions, depending on the case. Although the political-discursive idea was to create a social security policy, what was imprinted in this law was a restricted set of social securities for the population that had settled in the main urban centers and worked in industry and services. This idea was far from Beveridge's notion of social security.

The nineties is marked by neoliberal modernization initiated at the end of the eighties when the IMSS was placed on the path to its dissolution as a hegemonic body that once was the sole provider of retirement benefits. The IMSS's financing modality was also modified in a radical and structural way: it went from being a distribution system to being an instrument of private capitalization.

The social security problems in Mexico can be listed briefly: limited coverage in terms of the working population and in relation to the total population in spite of the existence of a law and an institution close to celebrate its sixtieth anniversary. The public systems of social security currently include 50% of the total population and 30% of the economically active population. A historic deficit of health care and maternity insurance hovered over the work risk insurance and retirement funds for almost 50 years. It is on this deficit that the government based part of its argument to justify the privatization of the pension scheme. There has also been a historically small number of retirement

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pensions. The Zedillo administration attributed this scarcity to the funding system without recognizing the government's responsibility for the inefficient management of the reserves and its neglect towards the IMSS in the past 20 years, which has nevertheless provided health care to the marginalized and uninsured rural population, almost 11 million individuals in the year 2000.

In another field of ideas, the social security system, the government and society did not adapt to the dramatic changes in life expectancy, the resulting extension of active labor life, and the polarization of the epidemiological profile. Although the IMSS was founded with the clear awareness that it was not embracing the idea of social security, but rather of social insurance only, in those far away years it aspired to incorporate all Mexicans by the turn of the decade, a goal that has not been reached yet.

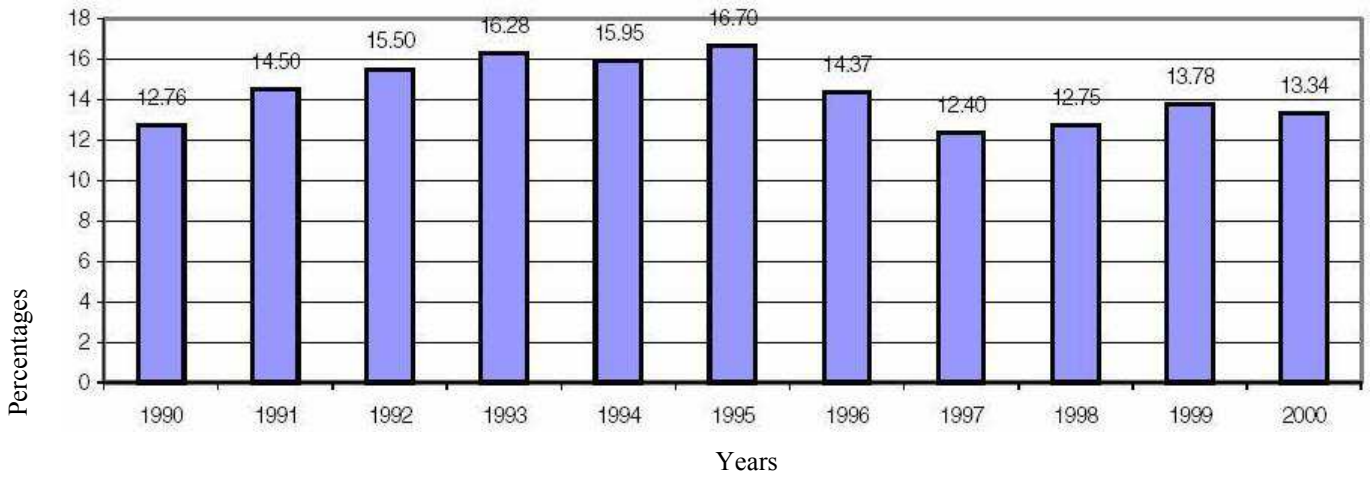
MEXICAN SOCIAL SECURITY SYSTEM THROUGHOUT THE DIFFICULT AND CRUCIAL NINETIES

The Mexican economy in the nineties presented signs of economic recovery. However, by the end of 1994 and all through 1995 there was a deep financial and banking crisis. The macroeconomic variables recorded some growth from 1990 to 1994, but with the crisis they dropped dramatically and did not start their recovery but until 1997. Public institutions like IMSS reflected this macroeconomic situation. From an overall perspective, throughout the nineties, IMSS expenditure and income on average accounted for 2.3 and 2.4% of the country's economic growth; an extremely low figure if compared to developed countries and even developing economies.

In the nineties, IMSS's expenditure share in the programmable federal expenditure was observed to increase annually for almost all years until 1995 except for 1994 when it dropped to 15.95%. This can be explained by the financial and banking crisis. In 1996 and 1997 the social security expenditure recorded rates of 14.37% and 12.40%, respectively. Growth was resumed in 1998, but less dynamically than in the first years of the decade (graph X.1.).

Due to modifications to the IMSS law, two different forms of income and expenditure distribution are present in the period under study (1990-2000). The first stage goes from 1990 to 1996 and the second from 1997 to the year 2000.

Graph X.1. *IMSS Expenditure Participation in Programmable Federal Expenditure 1900 - 2000*

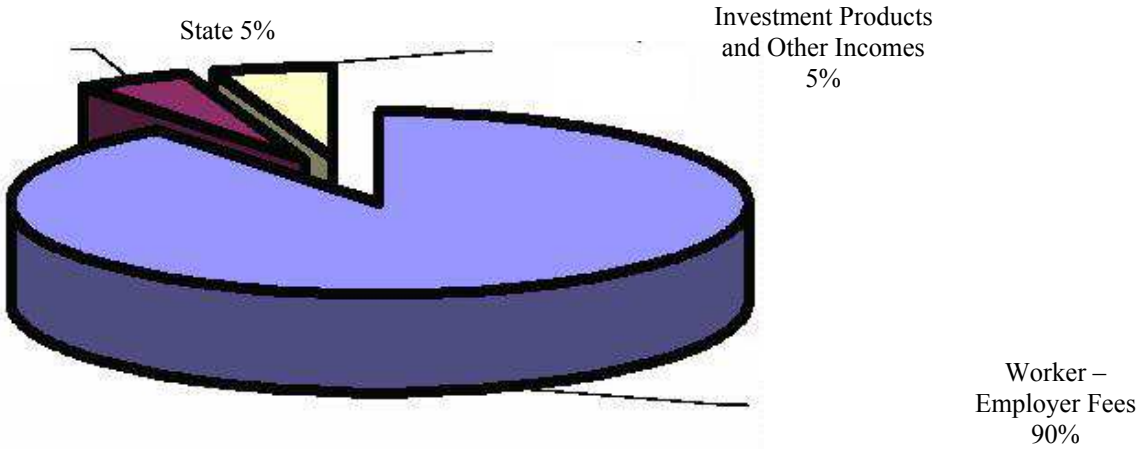


Note: Expenditure figures refer to expended expenditure.
SOURCE: The author's own estimates based on *IMSS memoria estadística*, Mexico, 2000 and Banco de México, *Estadísticas Económicas*. Mexico, 2000.

From 1990 to 1996 the highest source of income is occupied by fees paid by workers and employers (90%), investment earnings and other incomes (5%), and the State's contribution (another 5%). From 1997 to the year 2000, these figures changed to 71, 10 and 19%, respectively. It can thus be deduced that the State is the most dynamic source of funding for this institution

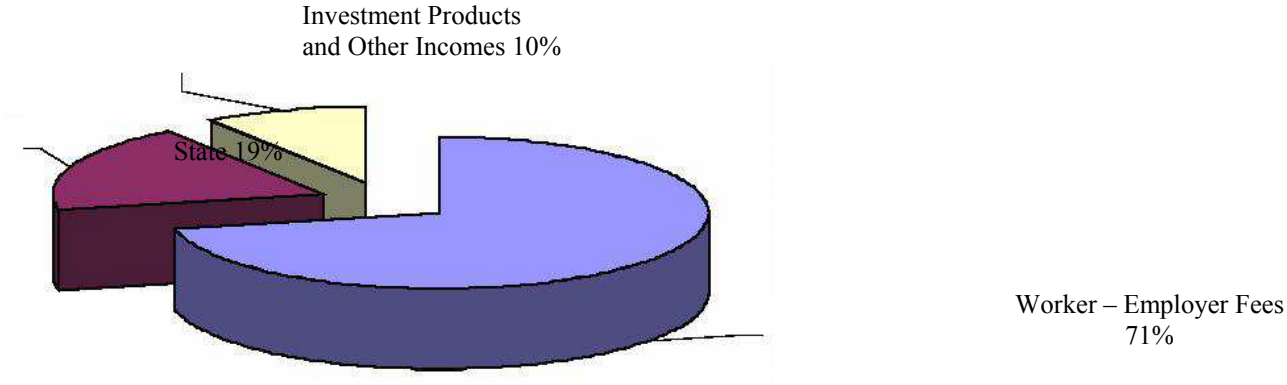
(graphs X.2. and X.3.). It should be noted that in 1980, the State accounted for 12% of the IMSS's income (Moreno, 1991) this went down to 5% in 1990 and up again to 19% in the year 2000, without disregarding the fact that the IMSS reform in 1995 led to increasing the State's fiscal cost.

Graph X.2. *IMSS. Income Distribution 1990 – 1996 (Percentages)*
1994 = 100



SOURCE: The author's own estimates based on *IMSS memoria estadística*, Mexico, 2000 and Banco de México, *Estadísticas económicas*. Mexico, 2000.

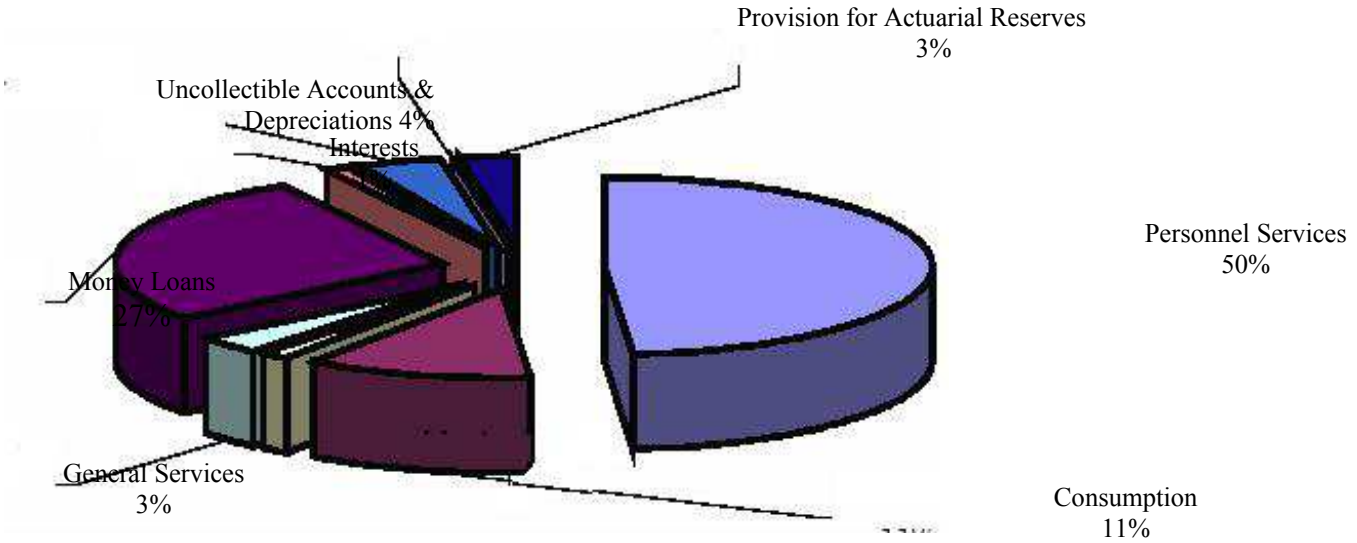
Graph X.3. *IMSS. Income Distribution 1997– 2000 (Percentages)*
1994 = 100



SOURCE: The author's own estimates based on *IMSS memoria estadística*, Mexico, 2000 and Banco de México, *Estadísticas económicas*. Mexico, 2000.

Between 1990 and 1996, expenditure was distributed as follows: 50% was allocated to personnel services, 27% to benefits in cash, 11% to various forms of consumption, 4% to uncollectible accounts and depreciations, 3% to general services, 3% to provisions for actuarial reserves, 1% to interests, 1% to maintenance and –0.03% to adjustments to the results of the actuarial exercises (graph X.4.).

Graph X.4. *IMSS. Income Distribution 1990– 1996 (Percentages)*
1994 = 100



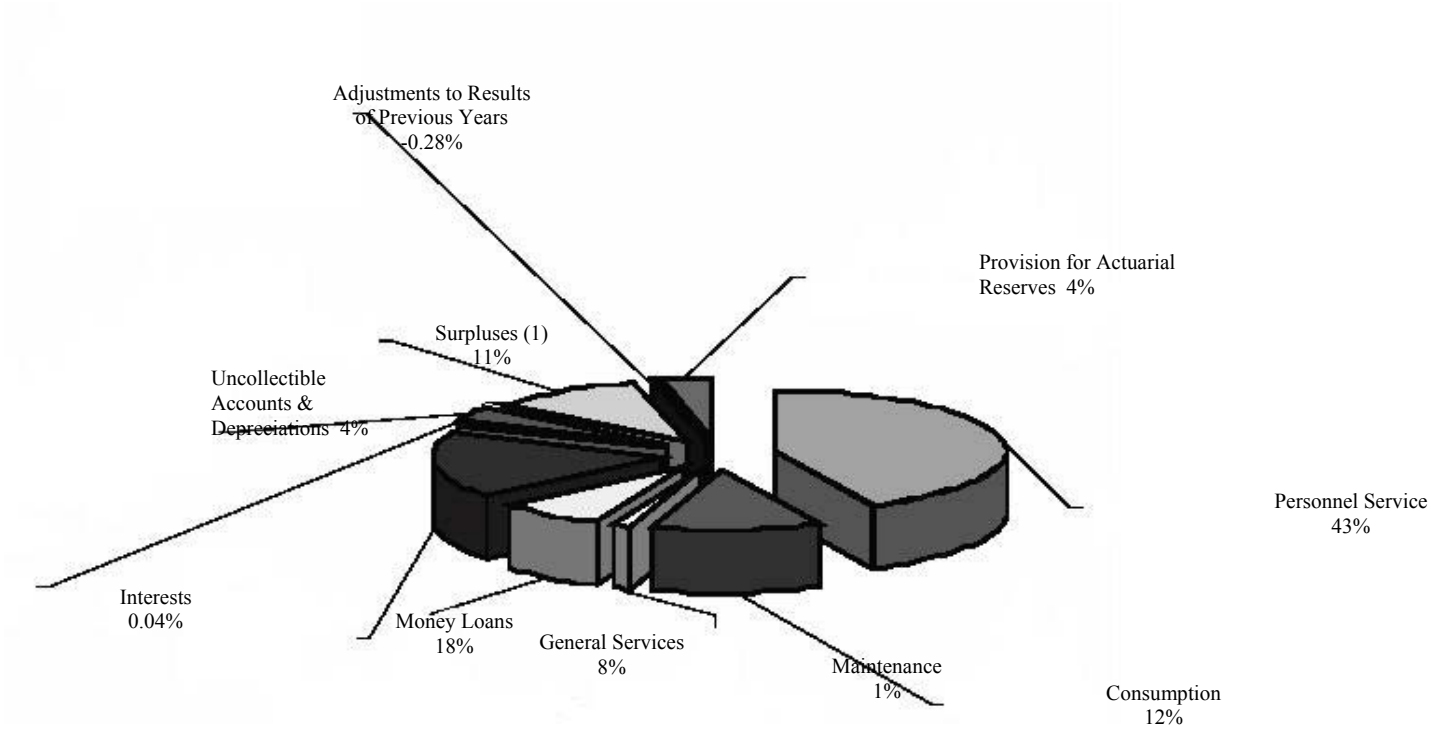
SOURCE: The author's own estimates based on *IMSS memoria estadística*, Mexico, 2000 and Banco de México, *Estadísticas económicas*. Mexico, 2000.

From 1997 to 2000, a new item was added: overexpenditure thus reducing the rest of the variables composing expenditure: personnel services were reduced to 43%, benefits in cash to 18%, interests to 0.04%; general services were increased to 8%, as well as provisions for actuarial reserves to 4%, adjustments to the results of previous exercises went down to –0.028% and consumption increased to 12%; uncollectible accounts and depreciations remained at 4% and maintenance remained at 1%; and, finally, overexpenditure went up to 11% (graph X.5.).

When comparing annual growth rates of income and expenditure we can see they both recorded negative rates: -11.58% and -8.51% for the former in 1995 and 1996, and -17.54% and -5.88% for the latter, which is reflects the 94-95 crisis as well as the 1995 social security reform, aftermath (comprising elements such as the adjustment of both requirements and benefits and the incorporation of the capitalization component to both contributions and benefits (Bravo, 2000)). Both variables presented a similar growth level until 1994. After 1994, however, the income curve grew more than the expenditure curve, a situation that changed in 1999 when expenditure was higher than previous years. It should be noted that incomes recovered more rapidly than expenditures. In 1997, incomes presented a rate of 7.02% and expenditures a rate of –4.06%. From 1998 to the year 2000, both variables behaved very similarly. In 1998, there was an increase of over 8% in order to then drop again to 1% levels (graph X.6.).

Income and expenditure growth both indexes recorded a tendency to increase from 1990 to 1994, in fact both of the curves traced on very close together. The 1994-1995 crisis caused a drop in both variables, specially of incomes that recovered so rapidly that since 1997 the income curve has been higher than the expenditure curve, which is why income growth registered a greater dynamism throughout the period (graph X.7.).

Graph X.5. *IMSS. Expenditure Distribution 1997– 2000*
1994 = 100



SOURCE: The author's own estimates based on *IMSS memoria estadística*, Mexico, 2000 and Banco de México, *Estadísticas económicas*. Mexico, 2000.

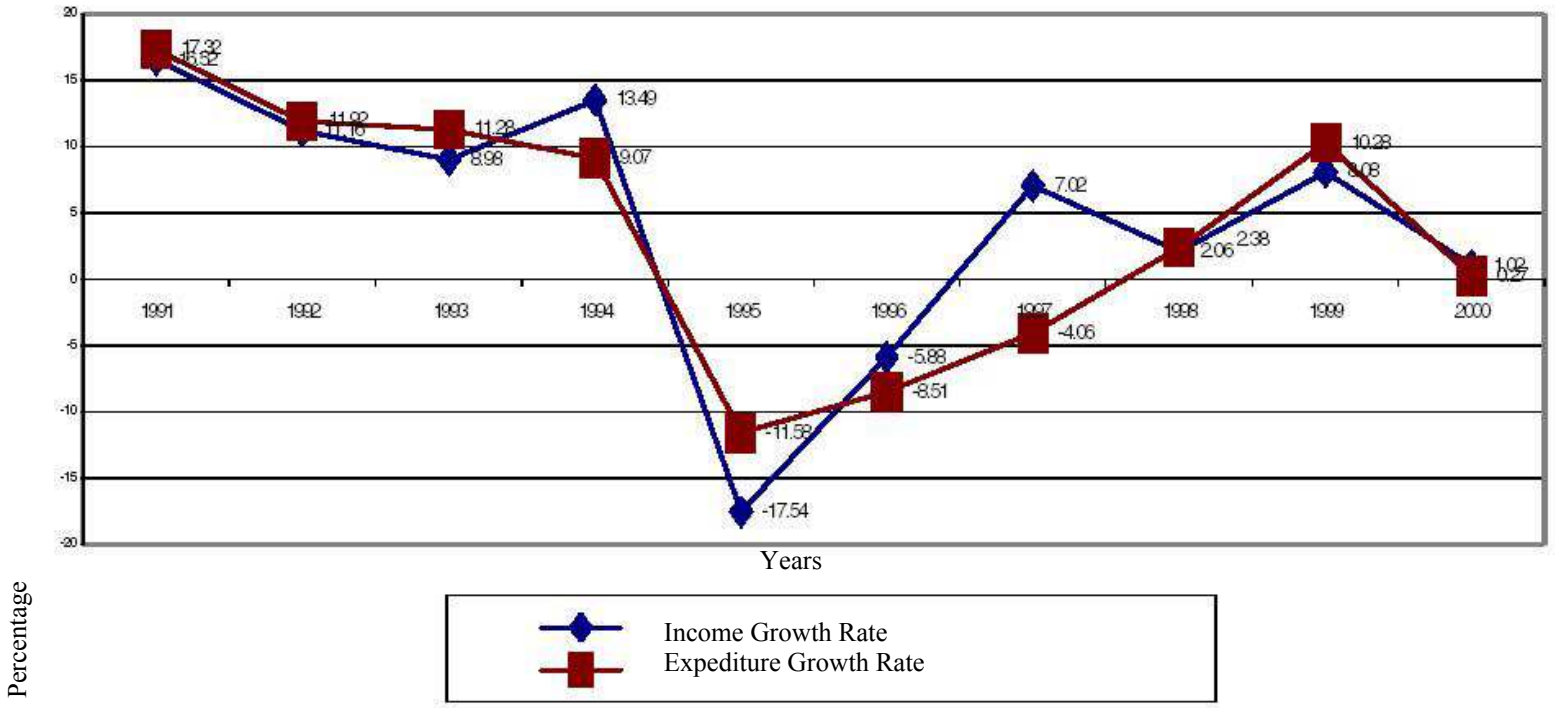
On the other hand, the average growth rate of income and expenditure for 1990 - 2000 was 43.42% and 35.44%, respectively. This was indicating a greater income dynamism, despite the country's macroeconomic situation in spite of the 94-95 that directly affected employment levels and wages, causing a decrease in the the participation of the workers' and employers' fees in the IMSS income. This, however, was compensated by an increase in other sources of state funding and by products and investments, as observed in graphs X.2. and X.3. where the State's contribution tends to grow more.

IMSS funding presents two problems: either firms are not up-to day on their quotas or they are simply not within the formal side of the economy. At present, 15,000 companies owe the IMSS 22 billion pesos, equivalent to 16% of its budget in the year 2001, and it is estimated that the IMSS will only recover 4 billion pesos (Cruz, 2002). While two million companies of the informal economy do not pay taxes (Zuñiga, 2002), and therefore do not pay social security dues, thus directly affecting the workers' quality of life.

Results demonstrate that in spite of a critical situation in its finances in 1994 and 1995, the IMSS did not suffer any deficits from 1990 to the year 2000 and, on the other hand, the recovery from 1997 to the year 2000 was remarkable and can be explained by the income composition where State funding increased, particularly between 1997 and the year 2000 (see graph IX.8.), trying to making up the loss of contributions of the retirement insurance that by law had to be handed over to AFORES, the current administrators of retirement funds.

The per capita annual expenditure growth rate showed a constant increase until 1994 and since then it went on decreasing until the year 2000 (graph X.9.).

Graph X.6. *IMSS. Annual Growth Rate of Incomes and Expenditures 1990 – 1996 1994 = 100*



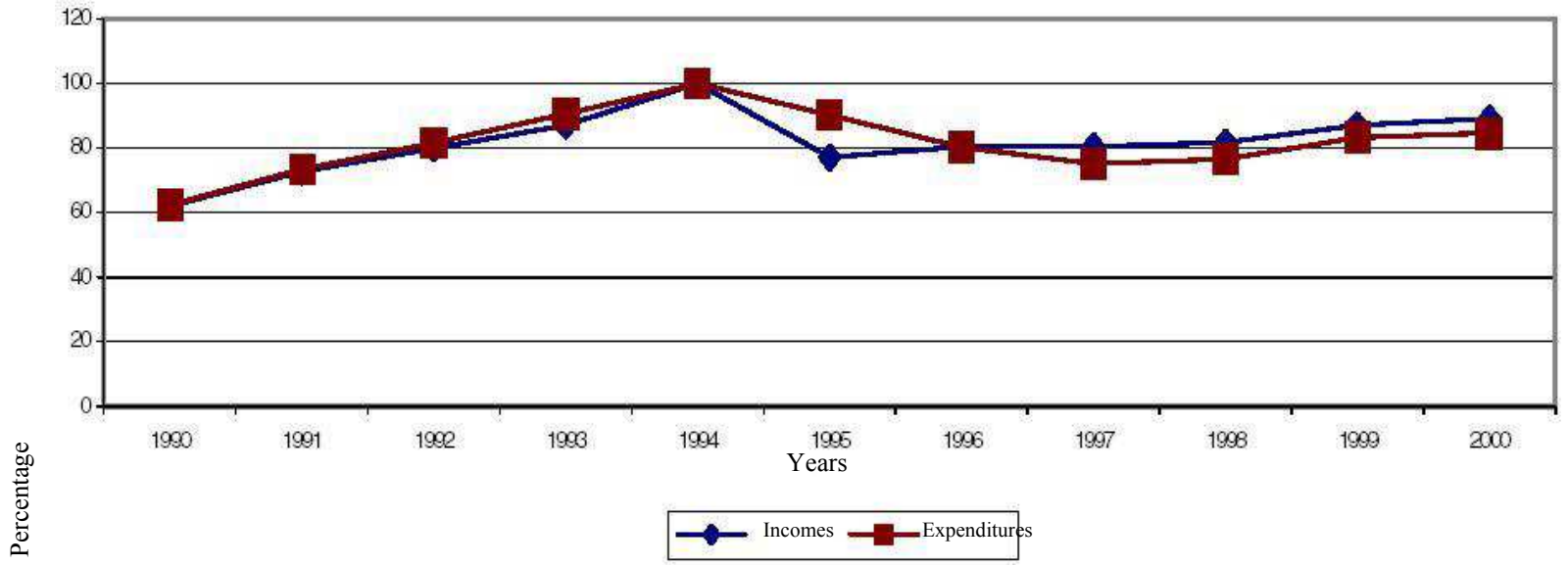
SOURCE: The author's own estimates based on *IMSS memoria estadística*, Mexico, 2000 and Banco de México, *Estadísticas económicas*. Mexico, 2000.

To analyze the insured population and IMSS membership, we compiled information that goes back to its creation in 1943. We noticed that the rural population was no longer included after 1956. The total population's growth trends, both rural and urban, were very similar in the first two decades but then the urban population curve is quite close to the total population curve; as opposed to the rural population curve that, apart from growing more than the other two curves between 1989 and 1992, from 1997 to the year 2000 it dropped below them. This drop can be attributed to specific policies exogenous to the IMSS (graph X.10. and table X.1.).

The dependency coefficient reflects growth throughout the period that since the mid-nineties accentuated; 1995 is the year in which the greatest dependency coefficient was recorded, which is explained by the economic crisis in Mexico that affected economic activity (table X.2.). The reform started to be enforced in 1997 and so the coefficient's value is rather symbolic, since in fact the IMSS is no longer in charge of the contributions for the retirement insurance. This dependency, however, may partly explain the increasing deficit in the coverage for non-occupational illnesses and maternity.

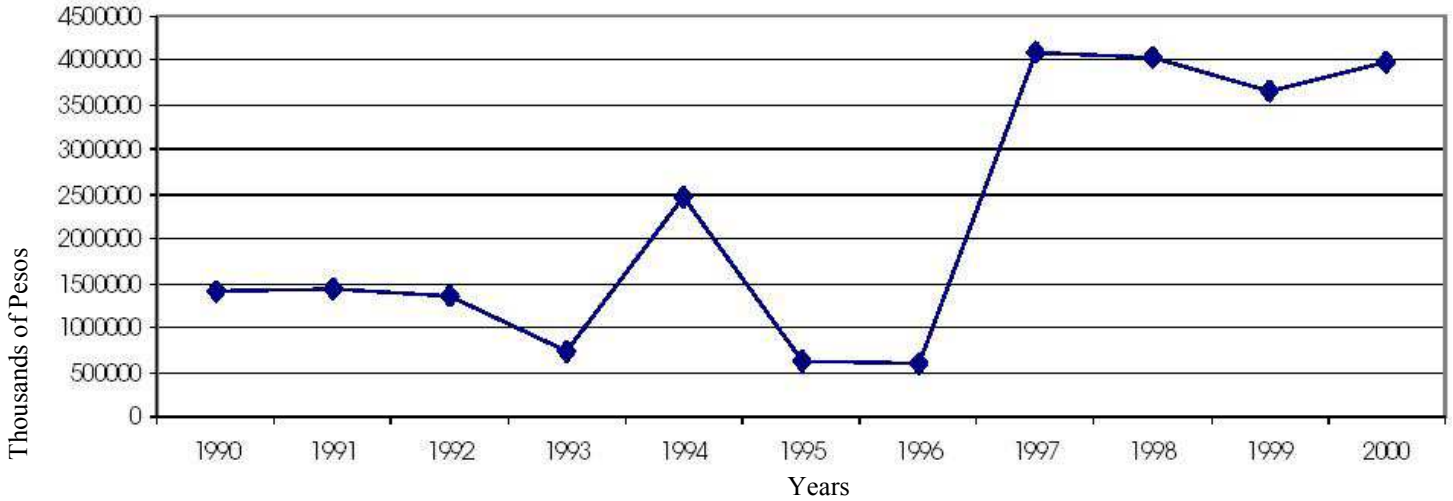
In fact, because of the structural reform in 1995, reflected in the statistics we present here, the IMSS experienced a period of severe discontinuities and disruptions in the nineties. Highly pronounced disruptions emerged between 1994 and 1996. They were a consequence of the crisis, but above all of the reform-related decisions and the measures taken by the government in order to compensate for some of its effects. It was without doubt in this period that the collapse of the social security paradigm was gestated, a paradigm specific to Mexico since 1943 that reached its peak development in the seventies. Social security in Mexico is on the verge of using the back door to cross into an "insurance system" similar to the one prevailing in the thirties.

Graph X.7. *IMSS. Annual Growth Rate of Incomes and Expenditures 1990 – 2000*
1994 = 100



SOURCE: The author's own estimates based on *IMSS memoria estadística*, Mexico, 2000 and Banco de México, *Estadísticas económicas*. Mexico, 2000.

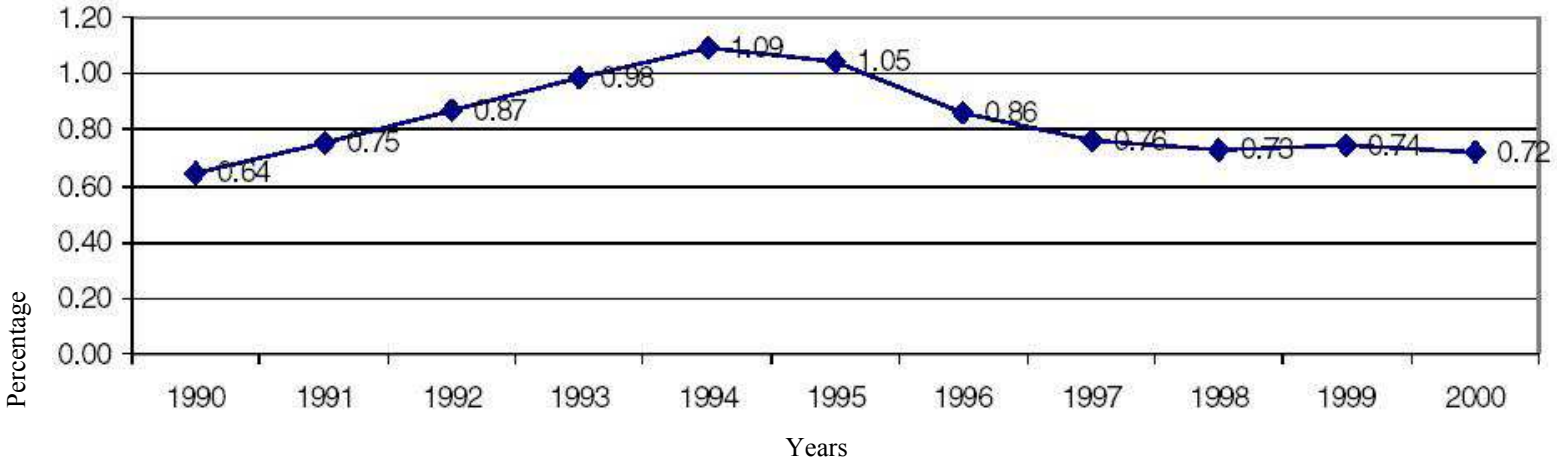
Graph X.8. *IMSS. Result Status 1990 - 2000*
1994 = 100



SOURCE: The author's own estimates based on *IMSS memoria estadística*, Mexico, 2000 and Banco de México, *Estadísticas económicas*. Mexico, 2000.

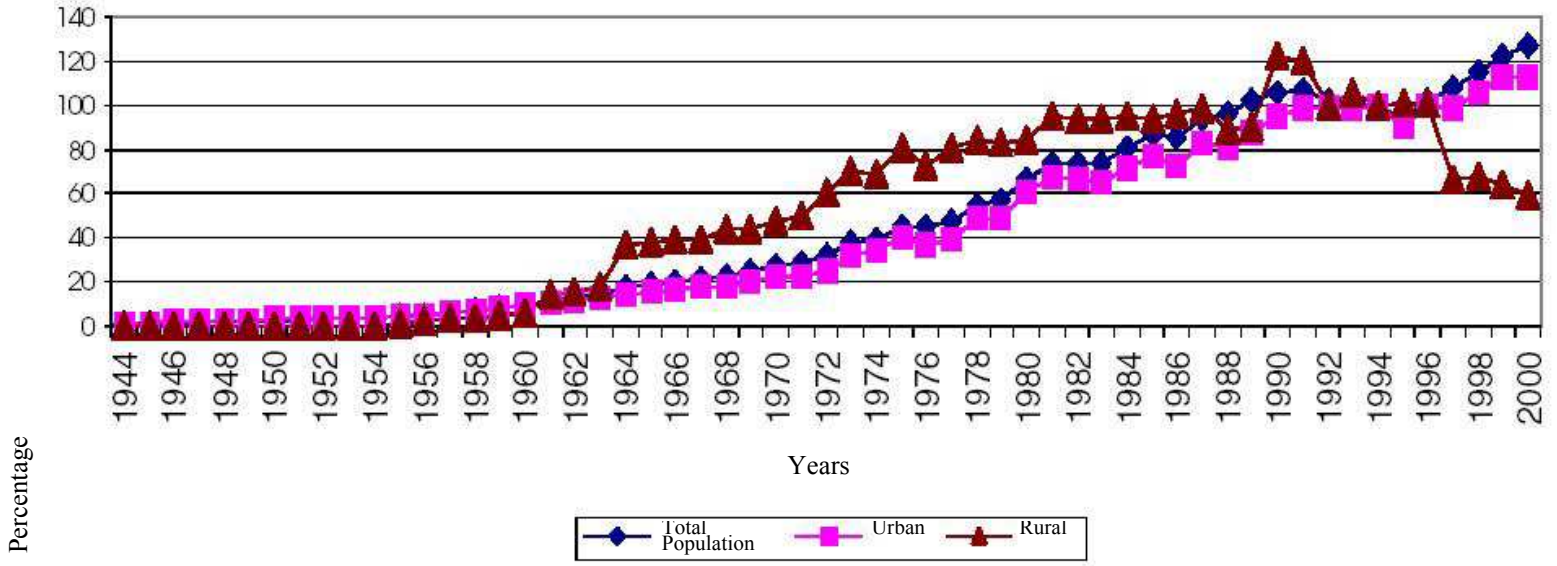
In general, the IMSS had no important deficits throughout its lengthy history. It nevertheless did present chronic deficits in non-occupational illnesses and maternity, which it remedied with resources from retirements, work accidents and occupational illnesses; the contributions made by both employers and workers were always low in relation to the cost of the benefits and services it offers, and the conditions or requirements needed to enjoy these benefits and services have been extremely generous, to say the least. The State maintained and encouraged this inner operational logic at all costs via a corporate institutional re-arrangement aimed to encourage stability.

Graph X.9. *IMSS. Per Capita Growth Rate 1990 – 2000*
1994 = 100



SOURCE: The author's own estimates based on *IMSS memoria estadística*, Mexico, 2000 and Banco de México, *Estadísticas económicas*. Mexico, 2000.

Graph X.10. *IMSS. Total Population Index (Urban and Rural) 1994 – 2000*
1994 = 100.



SOURCE: The author's own estimates based on *IMSS memoria estadística*, Mexico, 2000 and Banco de México, *Estadísticas económicas*. Mexico, 2000.

An evaluation from a workers' perspective of the structural reform of the pension system (1995)

According to Mesa-Lago (2000), the reform of Mexican Social Security Law is a structural reform akin to the one carried out in Chile where the system that used to finance the retirement insurance, which was based on a distributional idea, was replaced by another system of full and private capitalization in the risk market based on the establishment of individual accounts.

In Mexico, workers have face a major cost as there has been no compensation or payment for the forced transfer from the old system to the new one. In Chile, under the condition of being a contributor for at least 3 years, a generous bonus was paid which was adjusted to inflation and a 4% annual real interest was added (Mesa-Lago, 2000). Another, in this case, differed cost faced by Mexican workers is that in order to be eligible for retirement rights (and thus get their pension), they were enforced to pay fees for another 750 weeks in addition to the 500 weeks that were valid before the reform. One further, short-term cost is that the Mexican law, as opposed to the experience in Chile, did not ensure a reduction in the workers' fees for the compulsory transfer from the old regime to the regime based on private capitalization. And yet one other cost is that the workers in Mexico did not receive a real increase in wages, as they did in Chile where wages went up 10 per cent.

Table X.1. *IMSS. Insured Workers and IMSS Members 1990 - 2000*

Year	*Total IMSS Members*	*Insured Workers Retirees and Relatives*	*Urban Areas*	*Rural Areas*
1990	38575140	2317155	11845839	892344
1991	38953374	2227517	12346355	874656
1992	37465460	2341203	12352134	727081
1993	36737601	2536215	12214899	770198
1994	36553822	2694097	12477104	730816
1995	34323844	2858535	11268240	739152
1996	37260967	2999849	12429394	739682
1997	39461964	3135212	12228678	485146
1998	41941674	3235481	13119319	491864
1999	44557157	3348816	14092898	466831
2000	46533924	3472044	14086277	433854

SOURCE: *IMSS memoria estadística*, Mexico, 2000.

However the most substantial cost has without doubt been the loss of intergenerational solidarity and of the protection against risks that entails the great possibility that almost 90% of the workers will not have the final minimum number of payments to enjoy a pension with their minimum wages and will have to resort to a state subsidy (Daniel and Rozo, 2002). It is also likely that they will face discrimination vis-à-vis a highly likely total privatization of health insurance (Martuscelli and Alonso, 2000) in the face of reiterated budget cutbacks resulting from the "success" achieved in the field of pensions as the World Bank would claim (Castellanos and González, 2002). Other insurance branches are also at risk of becoming privatized.

What is not made explicit is that it is the workers themselves who sustain these benefits (De Buen, 2000; Soto, 2000). The benefits are only macroeconomic: national savings derived from the privatized pension funds reached 50 billion dollars in the year 2002, almost 9% of the GDP. Although 95% of these funds are placed in government stocks, it is argued that these funds are being invested in productive projects that will generate attractive earnings, derived more from speculative than productive investments for the new worker-investors. No mention is made of their future pension. Neither is said about the urgent need to increase their real wages a measure that would partly influence an increase in compulsory and perhaps even voluntary savings (Daniel and Rozo, 2002). The risk of holding pension funds in stocks, under the current economic conditions of the Mexican economy, increases uncertainty in this sector. We should not ignore the fact that the *moral hazard* is a repeated phenomenon in Mexico; the State historically has rescued actors located in different economic activities.

The AFORES commission structure has drastically reduced the amounts of money to be invested in the workers' individual accounts, but not the profits of the companies in the sector. Besides, it is agreed that it is 10 to 18 times more expensive to manage an individual accounts system than the previous system (Soto, 2000; Mesa-Lago, 2000; Daniel and Rozo, 2002). In spite of all the institutional redesigning that led to the most important reform in the history of Mexico, there is increasing uncertainty about pensions. Although affiliation to the new system grew vertiginously from 4.5 millions workers in 1997 to 16 millions in the year 2002, something similar to

what happened in Chile might occur: disaffiliation or the moratorium might grow, against all liberal rethoric once workers become owners of their beneficial savings, will they punctually comply with their obligations? (Mesa-Lago, 2000).

Table X.2. *IMSS Dependency Coefficient 1990 – 2000*

Year	*Insured Workers*	*Annual Growth Rate*	*Retirees*	*Annual Growth Rate*	*Dependency Coefficient* [1]	*Retirees per Insured Workers*
1990	10,764,012		1,174,321		109	9
1991	11,333,485	5.29	1,218,240	3.74	107	9
1992	11,368,526	0.31	1,258,616	3.31	110	9
1993	11,317,348	-0.45	1,352,159	7.43	119	8
1994	11,561,004	2.15	1,432,736	5.96	124	8
1995	10,931,810	-5.44	1,521,796	6.22	139	7
1996	11,895,198	8.81	1,602,629	5.31	134	7
1997	12,713,824	6.88	1,680,629	4.87	132	8
1998	13,611,183	7.06	1,734,945	3.23	127	8
1999	14,559,729	6.97	1,797,016	3.58	123	8
2000	15,240,131	4.67	1,861,058	3.56	126	8

[1]Out of every thousand insured workers.
SOURCE: Cámara de Diputados, *CEFP, El gasto público federal en seguridad social 1990-2001*.

Further from solving pension insufficiency, what other reasons could there be behind conducting such a radical reform in Mexico that cannot be compared to any experience in North America or Europe, and can only be compared to two other cases in Latin America: Bolivia and Chile? Some academics provide two complementing explanations. The first explanation is internal and has to do with eliminating distortions in the labor market and promoting capital accumulation (Martuscelli and Alonso, 2000) which is the core thesis behind the reform. The second explanation is external and is related to the depletion (and inability to generate) of domestic savings and the voracious search for these priced flows in underdeveloped countries (Daniel and Rozo, 2002). The underlying political reasoning was that that the corporate network crumbled and the setting up of a de facto political project with strong external commitments that be to export-oriented development (Ibarra, 2002).

These two theses are certainly applicable to all Latin American countries that underwent reforms, even if not as radical as that of Mexico. An additional factor to consider is the size of the Mexican market, currently the largest in Latin America. The volume of resources represented by the pension funds of the seven countries that have reformed their social security systems, as measured in 1997, amounted to an average 8.5% of the combined GDP; data for the year 2000 reveals an increase to 11.2% and a projection to the year 2015 came up with 26.3% of the combined GDP. National figures for the latter year fluctuate between 52.9% in Chile and 7.8% in Uruguay (Daniel and Rozo, 2002).

An Evaluation of Health Care Reform

Throughout the last two decades a vast literature was produced on the need to improve efficiency, quality and equity in health care. This idea helped justify the bills for a reform promoted by different international developing agencies, notable the World Bank (*Invertir en salud*, 1993; World Bank, 1998; World Bank, 2001).

Four years after the IMSS Law was reformed and the Health Department (Secretaría de Salud / SSA) made some changes at a federal level, as some studies anticipated there is a greater inequity in health and a stratification of the population according to paying capacity.

In Mexico, the World Bank's prescriptions for health have materialized in a model called *structured pluralism* (Frenk, 1997; OMS, 2000). Its premise is that the market is the great regulator and that its dynamic can solve the essential conflicts between efficiency and equity. This proposal

taken on as part of the current administration's health sector program reinforces changes that were already in course, such as administrative and functional separation at an institutional level; greater participation of private capital in administration and the provision of services and, particularly the stimulus for the emergence and reinforcement of mixed models that give origin to different forms of relating the public and the private based on public subsidies to private administration and service provision.

These modifications imply the abandonment of the social welfare logic that characterized the national social security doctrine and the adoption of accumulation and profits logic, which denaturalizes the social idea that gave birth to it by making it nonsensical. (Tamez and Moreno, 2000).

Laws and programs have experienced many and very important modifications. We will mention some examples that illustrate the importance of these changes and their correspondence to the reform's goals.

The notions imprinted in the Reform Program for the Health Sector 1995-2000, aimed to the uncovered (uninsured) population, and the changes to the IMSS Law proposed in 1995 but not formalized until 1997, played an essential role in preparing the ground for a deep re-organization of health care. In the first case, the program's adressing to the uninsured population were: decentralization of federal resources to provide open population with health care; expanding the coverage through a basic package[1] and a new organization of the health system model based on the configuration of three groups: the population covered by private insurance; by extended social security and by state health systems together with the SSA and IMSS-PRONASOL systems (Tamez and Molina, 2000).

Accordingly, the most important changes within the Social Security Legislation purposed to reach goals such as differentiation of finances and the services provided by the institution, a rise of receipts through reliance in state subsidies and the inclusion of workers of the informal economy. At a more specific level the fees system changed from one based on a proportion of wages to one consistent of a uniform contribution, indeed not a scheme that promotes concurrence. Another change was the creation of a voluntary insurance based on the establishment of family insurance, the purpose of which is to capture the middle strata of the population with paying capacity. One other noticeable change acted upon the fee reversal mechanism so that now employers are able to withdraw up to 40% of the health and maternity insurance funds in order to choose a health care alternative for their workers (Tamez and Moreno, 2000).

The most conflictive theme was the modification to the fee reversal system. As mentioned, through this scheme employers can request a reimbursement of the fees if they can demonstrate that they will provide the service appropriately. The issues is that the amount that is given back includes the State's contribution. This mechanism will become a way in which the public sphere will subsidize the private sphere since many of the bodies hired to provide the service will be private.

Besides, in order to delineate the proposal regarding IMSS health care provision, it was necessary to sig and accept the conditions established for a World Bank loan of 700 million dollars in 1998 (World Bank, 1998), which advances in the health care marketing logic. This agreement laid the foundations of the norms for the administration of funds and the provision of services to 43 million Mexicans.

On the other hand, there are specific legal modifications that complement the most important changes, such as the passing in 1999 of the Law on Health Maintaining Organizations (Ley de las Instituciones de Seguros Especializadas en Salud or ISES) promoting the creation of private service providers (Organizaciones Administradoras de Servicios, also called Deconcentrated Medical Management Areas (Áreas Médicas de Gestion Desconcentrada / AMGDs), organizations in charge of organizing health care, providing or outsourcing services, which will compete with public bodies for "clients" (Laurell, 2001).

As a result, the globalizing policies that in discourse propose goals such as fighting inequities in health, improving health quality and financing conditions have managed to place the interests of private capital, usually foreign, in the center of the goals of the health care reforms. As

[1] The package was originally to be applied in 380 highly marginalized municipalities in 11 states with a total of 4 million inhabitants, 30% of which do not have access to any regular health care.

stated in *La reforma de salud en México*, a document published by the Mexican Foundation for Health (Fundación Mexicana para la Salud / FUNSALUD) that develops strategies to promote private sector participation along some of the lines established in Frenk's work (1994) that were taken up by the World Health Organization (WHO) in its World Health Report for the year 2000, which according to Soberón coincide with "the current administration's proposal to democratize health" (Soberón, 2001).

Surprisingly, these strategies basically coincide with the Health Department's National Health Program (SSA, 2002) since they establish a series of "priority actions" in order to "democratize health":

a) To establish a national health insurance through stages. The first stage will address the population in cities with over 100,000 inhabitants without a right to social security. According to the aforementioned analysis, the selection criteria for these population groups were: their "geographic location and their partial paying capacity" (*ibid.*). The document states that a basic health package applied to scattered rural populations will be used as the basis to bring more equity into the system. It defines the package as "the minimum health interventions that should be granted to all the population in response to priority needs".[2] It also states that efforts will be made, "within reason to increase its thirteen cost-effective interventions" as well as "to make private insurance complementary to basic public health care" (*ibid.*). It also analyzed the family's paying capacity and developed a tier subsidy system in order to avoid "adverse effects" on the family wallet. The IMSS family insurance was established as this proposal's costs framework and it is estimated that the federal government will have to spend 17 billion pesos, corresponding to 0.29% of the GDP, which demonstrates the proposal's viability. It aims to incorporate almost 21 million people in the first stage.

In this proposal, it is clear that the National Health Insurance coincides with the goals and strategies set forth since 1995 in the Reform Program for the Health Sector 1995-2000 and the modifications to the Social Security Law 1995-1997. This situation would without doubt lead to what has been defined as "a new fragmentation of the system that legitimizes market inequities. That is, the services for the wealthy, for waged workers and for the poor have marked differences in terms of timeliness, efficiency and quality" (Hernández, 2000).

According to WHO, Mexico is the Latin American country that devotes the lowest percentage of its public expenditure to health (WHO, 2000). Thus between 1991 and 1998, the public expenditure in health *per capita* decreased from 352.8 to 340.8 (thousand pesos), which implies a 3.4% reduction (INEGI, 2001). On the other hand, observing how the budget is distributed in administration, preventive care, health care and construction of health care units, it should be noted that whereas the first three showed minor modifications between 1990 and 1999, the latter suffered an important drop, since its participation went from 5.34 to 2.47%, which surely explains why the number of hospital units in this period did not growth (259 in 1990 and 257 in 1999) (SSA, 1990 - 1999).

The financial situation is aggravated by the effects of the dropping wages. It is estimated, for example, that 106 billion pesos in incomes were spent on health and maternity insurance between 1983 and 1994 (Laurell, 2001). On the other hand, although precise data are missing, financing has been affected by recent cutbacks to public expenditure ordered by the Federal Executive Branch, which has aggravated the sector's institutional crisis.

b) To apply measures in order to separate financing from service provision so that the IMSS´s financial situation can be relieved and improved. These measures have sensitively modified the health system's configuration in general and specifically define this institution's structure. Among the main modifications, in the future the IMSS's will only collect payments and norm activities of other instances, and payments for health and maternity insurance will be transferred to an autonomous body called Solidarity Health Fund (Fondo Solidario de Salud more on it below). This body must ensure a "financial ceiling" and transfer resources to health administrators, whether public or private. The baseline to estimate the amount of these resources will be the payment per member adjusted by age and sex, covering the actions of a package of services that could be complemented with an additional voluntary insurance.

[2] The Reform Program for the Health Sector 1995-2000 defined this basic package as low cost and high impact interventions —clinical, public health and health promotion— that it is feasible to implement.

c) To encourage the participation of the private sector in health care. The IMSS's deconcentration gave origin to the so-called Deconcentrated Medical Management Areas (Áreas Médicas de Gestion Desconcentrada / AMGDs) that have been defined as "economically self-reliant companies that compete for clients". These AMGDs will initially be constituted by the IMSS's 139 medical zones that will organize health care provision or outsourcing services.

d) To create a public fund for national health. The AMGDs will receive resources from the Solidarity Health Fund a big public fund endowing funds to private providers depending on their members' characteristics and providing second and third level services, the latter with IMSS specialization units. The decentralization of institutions that see to an open population led to the creation of the State Health Systems (Sistemas Estatales de Salud / SESa). IMSS members will receive health care at the AMGDs and those who do not belong to the IMSS will go to the SESa. The National Health Institutes will provide third level services for this population group. Of course this scheme considers private providers as an option for any population group with paying capacity.

From the perspective of those defending the health care bill, it will be increasingly necessary to articulate funding and service provision, and it all seems to indicate that they will also promote the emergence of private bodies in charge of this articulation since it states that "with regard to private providers, the recent regulation of the Insurance Health Maintaining Organizations / HMOs (Instituciones de Seguros Especializados en Salud (ISES) foresees that these institutions will capture funds and articulate with private providers" (Soberón, 2001).

Many of these changes are just being conceived. However, with regard to the current re-organization of the IMSS services, some estimates note that the new scheme has not solved the problem of de-funding health insurance**,** since it seems that the institution's income has only increased around 5.3% in relation to the previous scheme, which does not solve the financial problem, since according to official data, the deficit is between 8 and 10 per cent.

The reasons that might explain this situation include the slow growth of family insurance due to its high cost, its restricted risk coverage and the long wait to access some therapeutic procedures, as well as the need to maintain its fiscal cost, since according to World Bank guidelines (World Bank, 1998), the State contributes with 13.9% of the minimum wages by insured family. On the other hand, the separation of the funds of each insurance has made health insurance have to pay rent to pension insurances for using their facilities.

The main argument in favor of encouraging private provision of health care is that the IMSS services are saturated. With regard to IMSS coverage, a tendency to decrease was observed in the nineties. It dropped from 77.5% in 1991 to 41.5% in 1993, recovering gradually until it reached a coverage of 64.3% of the total in 1999. Besides, it is estimated that out of its almost 50 million members only 60% currently use its services, and that 30% gain access to private services or services for the uninsured.

With regard to resources, between 1995 and 1999 the absolute number of beds increased by 40, the number of offices increased by 456 and the number of operating rooms increased by eight, the number of delivery rooms however was reduced by twelve. External consultation and surgical interventions increased 10.2% and 7.4% in the same period and hospital expenditure dropped by 2.3% (SSA, 1990-1999). Although there are no precise and trustworthy data on the private sector, some figures allow us to evaluate its growth. For the same period of reference, this sector increased its number of surgery rooms by 317 and its number of consulting rooms by 433. Services like external consultation, hospital expenditure and surgical interventions also increased 36.5, 38.1 and 8.8%, respectively. That is, comparatively, the private sector grew in a greater proportion than the IMSS (SSA, 1990-1999).

The private sector, however has grown way below expectations, which can be explained by different reasons. On the one hand, small establishments cannot compete with the large hospital centers as far as resources and certification requirements are concerned, and, on the other, funds have been channeled to specialization centers, surgical wards and treatment and diagnostic technologies (Laurell, 2001). In spite of this unequal growth, it should be emphasized that public sector efficiency is still higher, which can be observed on the basis of the following indicators: 7.8 times more consultations per office; double the number of patients per bed; 9.3 times more surgeries per operating ward and three more deliveries per delivery ward (*ibid.).* Consequently, the proportional increase in private participation in health expenditure as a percentage of the GDP is

mainly explained by an increase in health care costs, which has also become a factor that limits the expansion of private health care in an important way.

Facing this, the privatizing proposal assumes that as it is becoming nearly impossible to serve the "new affiliated population" (Soberón, 2001) the existing private infrastructure could be used through public funding. It also claims that service provision "must be redesigned in order to welcome and promote the user's freedom to choose health providers, thus facilitating the plurality of services offered, and establishing competition among providers. All this will lead to the constitution of a good blend of the public and the private, a condition pursued by the health reforms in course" (*ibid.*).

Finally, the proposal concludes that the strategy of separating funding from provision corresponds to opening services up to a "plural" scheme, in which all the stakeholders compete like in the private sector. In relation to this, emphasis is placed on the need to develop and apply a certification and norms framework that allows an efficient control of the quality of services and also alludes to the need to "create procedures for training and strengthening private services and to establish economic incentives. In this context, outsourcing, indirect provision of services and fee reversal schemes must be reconsidered and perfected" (*ibid.*), i.e., it is necessary to improve the main measures and instruments of the health system reform devoted to strengthen the participation of private capital in health care administration and provision.

PROBLEMS SURVIVING THE 1995 REFORM

It seems that the structural pension reform carried out in Mexico is not delivering the expected results. It won't as it mostly a hasty and therefore provisional resolution (Hazas, 2001). Even those cases where the funding system has been based on the full capitalization of individual accounts (a scheme thought to work as voluntary pillar supporting the compulsive pillar), like some European countries and the United States, are subject to short-term contingencies and long-term uncertainty.

Unless solutions geared by a social and long-term vision are developed, several problems will persist in underdeveloped countries such as Mexico. First of all, a the low coverage due to the systematic lack of consideration of the new forms of work, chronic unemployment, underemployment and, in general, unstructured work (Van Ginneken, 2000), or for other reasons for exclusion, such as gender, age, ethnicity or population or family type.

The second problem is that of insufficient pensions owed to different set of causes: the simplistic assumptions (Hazas, 2001) supporting the individual capitalization system; the previous irresponsibility of social security institutions; the State's negligence in the management of reserves; as well as that of other insurance branches – looking for high yields; and the financial markets infinite ability to draw in the pension funds which have not been channeled into productive investments but rather accumulated in financial paper so that interest rates have been pressed down causing dis-savings. All these decisions are based on other two equally ill-thought statements: *1)* that real salaries (wages and benefits) will remain constant, and *2)* that salaries will behave according to the workers' average wages.

The third great problem is that as pensions have grown meager and, thus, insufficient, pensioners have been urged to complement their incomes engaging in other activities, after their retirement so that, in fact, pensions have turn into mere subsidies all of which authorities have actually encouraged. One of the missing analytic elements is the lack of recognition that people are living longer years and that working life is also lasting more years. There is not enough public debate and programs that allow social acceptance to duly adjust retirement age.

Most experts on social security around the world and particularly in Mexico conclude that it is necessary to reform the reform in order for social security to remain collective, redistributive, and social before it is too late.

Table X.3. *Indicators of Material Resources and Services Provided by IMSS and the Private Sector, 1995- 1999*

Indicator	*1995*		*1996*		*1997*		*1998*		*1999*	
	IMSS	*Private Sector*	*IMSS*	*Private Sector*	*IMSS*	*Private Sector*	*IMSS*	*Private Sector*	*IMSS*	*Private Sector*
Material Resources										
Censusable Beds	28,294	34,496	28,230	34,601	28,226	33,031	28,118	32,965	28,334	31,241
Consultation Rooms	13,204	12,022	13,233	12,928	13,259	12,497	13,437	13,061	13,660	12,455
Operating Rooms	943	3,248	939	4,660	937	3,538	935	3,810	951	3,565
Delivery Wards	487	2,511	482	2,490	479	2,426	477	2,443	475	2,392
Services Provided										
External Consultations	96,830,889	6,652,145	99,744,814	7,277,209	103,269,673	7,709,120	103,901,186	7,363,691	106,789,885	9,080,405
Hospital Discharges	1,907,275	887,083	1,879,356	1,038,617	1,891,201	1,060,031	1,834,794	1,232,687	1,863,126	1,225,707
Surgeries	1,293,319	444,643	1,326,724	376,043	1,349,830	428,116	1,366,847	360,021	1,389,566	484,180
Beds	0.14	-10.41								
Medical Offices	3.4	3.6								
Operating Rooms	0.85	9.76								
Delivery Wards	-2.46	-4.74								
External Consultations	10.28	36.5								
Hospital Discharges	-2.3	38.1								
Surgeries	7.4	8.8								

SOURCE: The author's own estimates based on INEGI, *El ingreso y el gasto público en México*. México 1998, 1999 and 2001. SSA. Sistema Nacional de Salud.

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