HEALTH POLICY IN MEXICO:

With Special Reference to the U.S-Mexico Migrant Population*

by

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INTRODUCTION

The expansion of commercial trade resulting from the North American Free Trade Agreement (NAFTA) is increasing the significance of the U.S.-Mexico border. One of NAFTA's primary goals is to create jobs in Mexico, particularly in the border area, in order to decrease the flux of illegal immigrants from Mexico to the U.S. For this objective to become a reality, it is important to examine Mexican social policy, specifically health policy along the border. An efficient and equitable health system will undoubtedly help to retain Mexican citizens in Mexico, as well as continue to be a service option for those who cross the border to work, be it legally or illegally.

This paper primarily focuses on the National Health System and discusses the relationship between its various public and private components. Next, access to this system is analyzed from both legal and the practical points of view by reviewing actual population coverage and barriers to utilization. Access to services in cities along the northern Mexican border is compared to the rest of the country.

From this foundation, a particular focus is placed on responses from the health system towards population groups that are significant to the relationship between the U.S. and Mexico. These groups are Mexican workers in the U.S., and tourists and retirees in Mexico.

Finally, emerging national health policies and their impact along the border area of northern Mexico are analyzed. These policies address the response of U.S. health care companies towards NAFTA; the response of Mexican professionals who work along the border towards the challenges and opportunities presented by this treaty; and the emerging regulatory activity in response to this challenging phenomenon.

THE NATIONAL HEALTH SYSTEM

Current organization of the health system. The current National Health System is composed of three relatively autonomous subsystems: social security, assistance institutions and the private sector, with the Ministry of Health acting as the lead agency. The federal government, state governments, companies and families all contribute to the National Health System. Social security is financed by employers and employees, in addition to contributions from the federal government. Assistance services are supported by the federal government and administered by the Ministry of Health and the IMSS-Solidaridad program. Households, state governments and municipal governments also contribute to assistance services to a lesser degree through fees and contributions. Private care is paid by families, who pay market prices with very little assistance from private insurance.

Social security institutes (Instituto Mexicano de Seguridad Social - IMSS and Instituto de Seguridad y Servicios Sociales del los Trabajadores del Estado - ISSSTE) collect and administer contributions from employees and employers. The Ministry of Health and the state and municipal governments administer assistance services. In each case, resources are allocated based on historic budgets that are formulated by various criteria. Health need is one of these criteria, although other criteria have been more predominant.

Social security institutes, assistance services (Secretaría de Salubridad y Asistencia - SSA), the states and counties each have their own service providers. A minority of state social security institutes delegate services to the private sector or to ISSSTE (Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado, Social Security and Services for the State Workers Institute). The SSA decentralized its services to fourteen entities in the mid 1980's. These entities

were then combined with the services from the IMSS-Solidaridad program. The majority of private providers are physicians who work in private practice.

Social security mainly offers services to its dependents, giving them everything from community assistance, such as promotional and preventive services which are usually provided at their homes, to tertiary care. Social Security also offers some community health, preventive and emergency services to the community at large.

Assistance services provided by SSA are primarily targeted to the indigent population through the placement of facilities in areas of need and through variable, income-based fees. Private services are available for all segments of both urban and rural communities, with a spectrum of varied capability and quality.

Mexico's health services network has evolved and diversified, to a great degree, in response to various development policies. A glimpse to the past lets us understand the system's strengths and weaknesses.

HEALTH SERVICES ACCESS

The health system has not developed parallel to the problems Mexico faces. Mexico has the highest per capita income for medium income countries in Latin America, yet ranks ninth in child mortality and seventh in life expectancy at birth. In 1992, Mexico ranked second to last among 17 countries in Latin America in terms of the percentage of its national budget devoted to health. The health budget is also not distributed equally, with the poorer federal entities receiving the smallest health budget. Privileged regions and entities also exist: the six northern border states of Mexico account for 17% of the population, but spend 23% of the resources. Although the Federal District (Mexico City) accounts for only 6% of the country's total uninsured population, it receives 48% of the assistance budget. These budget insufficiencies and inequalities signify that 8 to 10 million Mexican citizens do not have basic health services. The proportion of the northern border population without basic health services is not specifically known.

Health conditions. At the northern border, 5.1% of the adult population thinks that their health is fair to poor, 2.6% claim a disability, and 1.1% has been hospitalized in the last year. Nationally, twice as many adults (13%) consider their health less than good. Almost twice as many are handicapped (4.6%), and the hospitalization rate is four fold (4.6%).

Legal access to IMSS services. The Social Security Law identifies the groups of workers and general population who can be protected by the social security's service package as established by presidential decree. Such coverage includes occupational health, basic illness, maternity, disability, long term care, unemployment of elderly and death, daycare for the insured party's children, and retirement.

This health insurance does not exclude pre-existing conditions nor limits medical attention. In theory, the insured party and his/her beneficiaries have access to all services provided by IMSS, from community health to tertiary care. General limitations relate to the technology available to the institute and the waiting time to have access to it. For maternity services, the insured worker must have enrolled in IMSS through a labor contract at least two months prior to receiving her benefits.

IMSS offers all medical services to eligible persons up to two months after the affiliate stops paying the premium due to unemployment, given that they were previously enrolled for at least two months. If an affiliate dies, their relatives have the right to all medical services for life, observing the same rules of age, kinship and economic dependency.

Although the Social Security Law encompasses the entire economically-active population participating in the formal economy, not all groups have been incorporated through presidential decrees. According to the National Health Survey conducted in 1994, only 49% of the population has been incorporated into IMSS.

Individuals who are not eligible for IMSS may join voluntarily. The recently approved reforms in IMSS regulations will allow greater voluntary affiliation due to a lower premium, given that the federal government will begin to offer a subsidy in 1997. The amount of this subsidy has not been yet specified, however.

Legal access to SSA (*Secretaría de Salubridad y Asistencia*, Health Assistance Department) services: The General Health Law establishes the programs that address the general health benefits to which every Mexican citizen is entitled as a part of their right to health protection. Being very broad, in theory these programs do not exclude any aspect of allopathic medical attention. In actual practice, however, only social security institutes are able to offer all general health services.

The assistance services offered by SSA are available based on patient demand, and to a lesser degree through delivery of community preventive services. SSA uses a sliding fee scale according to a patient's ability to pay in order to regulate access. Therefore, a socioeconomic assessment is conducted each time a patient requests services. The assessment places the patient in one of four categories, ranging from free service to a maximum rate. SSA regulates the rates of all services in rural areas, although some local authorities apply uniform fees in those places where they assume some responsibility for facility maintenance. Family planning services, vaccination, oral rehydration and emergency care are free throughout the country. According to the General Health Law, any foreigner who requests medical services will pay for them in the highest cost category.

IMSS-Solidaridad services are offered based on an inkind pre-payment made by the community. For example, the community provides community development work in exchange for the delivery of services. The contract is limited to preventive and primary care services, as well as second level hospital attention.

Legal access to private services: The General Health Law does not regulate private health care. Private providers can offer any kind of service at any price as long as the sanitary regulations of providers and facilities are met.

Some medical insurance companies have established agreements with private providers in order to supplement social security services, which by law are offered to every worker. These agreements usually offer a wide array of services and do not exclude pre-existing conditions.

Actual coverage of health services. The provision of health services alone does not necessarily translate into community health protection. The availability of resources is often a limiting factor, along with other economic, geographic and organizational barriers which prevent timely treatment.

The contemporary public health system favors insured individuals, who comprise 55% of the total population but consume 81% of the public health budget (see figure 1).[1] Approximately 34% of the population is covered by SSA and the IMSS-Solidaridad program. Therefore, in 1990 approximately 11%-13% of the population had no access to health services. Based on this estimate, between nine and 12 million individuals have no coverage. If actual service capacity and the percentage of the population in need are used as criteria, it is possible that as much as 21% of the population lacks health services. As will be discussed later, once economic, geographic and organizational barriers are also considered, as much as one-third of the population may lack access to adequate health services.

Private medical practice meets up to 60% of the population's demand for services. The indigent population uses these services for only one third of their total medical need, however. This level of use is in response to access problems and a lack of trust in the public health service. Private medical attention is expensive, however, and of a low technical quality in general.

One might assume that the popularity of private health insurance in the United States would influence its use as an option among northern border residents. According to the National Satisfaction Survey, only 6.8% of border adults have private health insurance, compared to 9.1% nationwide. According to the National Health Survey, however, only 2.4% of the population have private insurance for major medical expenses.[3] The National Satisfaction Survey also does not show substantial regional differences in terms of social security usage, which serves 48% of border adults and 49% of adults nationwide.

Service access barriers. The barriers that hinder access to medical care can be economic (high cost of services and prescriptions, inability to stop working or lack of income), geographic (services distant from the community or no services at all) or organizational (lack of patient trust or lack of treatment quality). It is appropriate to clarify that these barriers do not include situations in which an individual or family fail to identify health needs that are evident to the rest of the community.

Economic barriers are the primary obstacle for 43% of the people who need health care and have no access to it, followed by geographic barriers (42%). Organizational barriers are less important, affecting only (15%) of the total population and (34%) of the insured population (see figure 2). It is important to note that economic barriers remain relevant among the insured, affecting (23%) of that population. According to the National Health Survey economic barriers to health care are perceived by all social classes.

Access barriers preclude the satisfaction of an important percentage of felt needs. This dissatisfaction is even greater among the impoverished population (figure 1). Dissatisfaction is greatest concerning pregnancy and delivery services, which affect almost one half of all pregnant women who consider this medical attention as necessary and for whom traditional care is not fully adequate.

According to the National Satisfaction Survey, 5.7% of the medical needs among border adults are not met, versus 7.9% nationwide. The most significant access barriers at the border are organizational in nature, which affect 63% of the frustrated users. These relate primarily to their inability to set up an appointment at various institutions. Economic barriers affect 15% of border adults who do not have the money to pay for the services. Only 2.2% of border adults face geographic barriers, due to distant facilities. Organizational barriers hinder services to a lesser degree than at the national level (43%). Economic barriers are twice as troublesome for the country as a whole, impacting 31% of the users. Geographic barriers constrain utilization for 14% of adults nationwide.

Health services utilization. The affiliate's contribution to social security gives him and his beneficiaries the right to receive medical services for an extensive variety of health needs. Nevertheless, social security services accounted for only 65% of total doctor visits and hospitalization cases utilized by the insured population in 1994. A total of 7.6% of services were provided by SSA or IMSS-Solidaridad, 23% by private practice and 4.3% by other institutions (figure 2).[4]

These figures reflect a high level of dissatisfaction with social security services. This dissatisfaction could be due to quality of services, economic barriers, or geographic barriers. Individuals may be unaware of service availability, although this possibility has not been properly studied yet. This service overlap also implies that more than one third of total patient contacts treated by the private sector represent people entitled to social security.

The uninsured population resorts to private services more often than the insured population. Private providers account for 46.6% of the uninsured's total service utilization, followed by assistance services (33.6%) and other services (2.4%). It is interesting to note that as much as 7% of this population's service is provided by social security institutes, despite formal barriers to access.

Of the total service contacts made by assistance services in 1987, 25% were with insured people and 40% with the non-poor population. In total, 52% of assistance services are accessed by people who belong to one or both of these groups.

According to the National Satisfaction Survey, 45% of border residents went to a doctor in the past year compared to 53% nationally, and 68% saw a doctor two or more times. Twenty-six percent (26%) of border adults received a complete medical examination and 35% received at least a blood pressure check. Among women, 24% received a breast cancer examination and 29% received a cervical cancer examination (pap smear). Breast cancer examinations and blood pressure checks are more prevalent at the national level, where 45% and 28% received them, respectively. There is no regional difference in medical examinations or pap smears, but wider coverage was expected in the border region.

There is no noticeable difference between the northern border and the rest of the country in terms of the overall pattern of medical services utilization. At the border, 47% of adults utilized a social security institution for their last doctor visit, 11% used institutions like SSA, and 42% saw a private practice physician.

The border presents fewer geographic access problems due to service location, since only 10% of border users responded that the clinic they went to last time was not conveniently located. This geographic access problem doubles to 24% at the national level. Nineteen percent (19%) of the border population had problems setting up a doctor's appointment, and 24% considered the waiting period to be excessively long. These indicators are slightly higher at the national level (26% and 30% respectively).

The quality of interpersonal care does not vary by region, once different indicators are considered. In both cases, 16% of the users would prefer not to return to the same place where they had their first appointment. Between 9% and 10% of the users responded that the medical attention they received has inadequate or that they were not examined carefully. Between 16% and 18% think that the doctor/nurse were not truly interested in their problem, that the time allocated to the consultation was insufficient, and that no efforts were not made to insure their comprehension or their ability to follow recommended treatment.

The border population receives greater exposure to American health services than the rest of the country. During their lifetimes, 7.8% of border residents utilize health service in the United States.[5] In contrast, only 1.3% of residents nationwide use U.S. services. For border residents, 24% of those who received services in the neighboring country did so because they lived there, while 67% chose U.S. services because they represented a better quality option.

The Population Flux between the United States and Mexico and Health Services

The following will focus on several aspects of the Mexican health system which are particularly relevant to the mobile population which crosses the border between the United States and Mexico. Special attention will be given to the health services provided for legal and illegal Mexican immigrants in the U.S., Latinos from the United States who seek services on the Mexican side of the border and American executives working in Mexico, as well as the American tourist and retiree population residing in this country.

It has been estimated that approximately 4.1 million Mexicans live in the United States at the present time, with an annual growth of 200,000 to 500,000 people.[6] In 1994, the returning flux of Mexicans from the United States was 797,931.[7] It is also estimated that 335,242 immigrants send money to Mexico annualy.[8] It is likely that Mexican migration to the United States will increase considerably due to the present economic crisis.

The Mexican State Department reported 77,532 transmigrants in 1994, or Mexican residents who returned from work out of the country, mainly from the United States. Surveys to transmigrants at the ports of entry revealed that 533,523 Mexican residents in the United States crossed the border into Mexico, saying that they returned to this country temporarily or permanently.[9]

The migration phenomenon involves mainly twelve states in central Mexico, from which 70% of the migrants originate. Up to 16% of the young men from this region reside in the U.S. at any given time, which has a strong impact on the local social structure.

The Mexican government has tried to respond to the needs and opportunities that the U.S. migrant population presents. At the same time, it has been responsive to binational political proposals in order to contend with the problems that migration creates.

IMSS response to the migrant population. In 1990, IMSS expanded social security protection for international migrant workers, offering them a type of health and maternity insurance. The initiative responded, for the most part, to the call of Cesar Chavez and the United Farmworkers Union of America (UFWA) to protect their Mexican brothers. Soon the agreement was extended to offer IMSS protection through other unions and also on an individual basis. IMSS trained and assigned promoters in offices of Mexican Consulates in Los Angeles, Fresno and Chicago. In addition, it authorized IMSS authorities in all states to receive applications for farmworkers who were still in Mexico. The promoters in the United States advertise the program through the mass media and through information targeted to U.S. associations that serve farmworkers and Mexicans.

The maternity and health insurance that is offered to international migrants is identical to that which domestic workers receive in Mexico. The service is voluntary for these workers and excludes monetary loans. It does not reimburse the worker for being temporarily or permanently disabled, nor for risks in the workplace, however. In reality, the insurance is designed to protect the worker's family dependents who generally stay in Mexico while the worker travels to the United States. There are no restrictions or limitations for pre-existing conditions.

The insurance premium costs $520 per year, due in one or two payments. In special cases, as for UFWA members, monthly installments may be arranged. IMSS meets with labor unions and associations so that they can directly arrange enrollment and collect insurance premiums, thereby protecting coverage by ensuring that payments are not interrupted. Enrollment is open year round when arranged through a union or association. The worker pays 100% of the premium, even though the labor union or association's administrative costs are offered free. In some cases, credit has been provided for union members. A membership card is issued to the worker, as well as appointment cards for each member of the family who is enrolled, and similar documentation is also given to promoters in the various consulates. Beneficiaries may use this documentation to receive services from any IMSS facility in Mexico. Workers may utilize facilities available along the border if they are close to their jobs in the United States.

In Los Angeles, promotion and enrollment agreements have been signed with seven groups: UFWA, protecting about 10,000 beneficiaries; the United Agribusiness League, with about 2,000 businesses and about 60,000 members; Western Growers, with another 2,000 businesses and 50,000 workers; H & M Transportation Company that employs many of Mexican drivers; The Federation of Zacatecano Clubs, with more than 50 clubs and 300,000 members in Southern

California; United Farmworkers, with about 10,000 workers in the Cochella Valley; Mexican United Workers with an unknown number of members; as well as the Federation of Jaliciense Workers. UFWA workers are also covered in Fresno and in programs in Florida, Texas, Arizona and Colorado. In Chicago, IMSS has affiliated with a group of Philadelphia mushroom workers, as well as with a Club of Guerrerenses.

Between July of 1990 and April of 1994, the program enrolled close to 7,400 workers and a total of 36,700 beneficiaries. Fifty-seven percent (57%) of the enrollment is in the Los Angeles area, 10.9% in Fresno, 15.7% in Chicago and 16.5% in other areas.

Assuming that all Mexican recipients in the U.S. are current in their payments, IMSS obtains an annual income of about $3,823,368 from this migrant population. If this is the case, the program provides an excellent source of income given the low operational costs in a foreign country. However, given the large number of Mexican workers who migrate to the United States, about 797,931 people annually[10], program coverage is still very low.

IMSS promoters have not yet received any complaints by affiliate members or their beneficiaries. Although it is well known that the medical units of IMSS tend to be located in urban centers that are distant from where many families live, the same is true for private physicians they would otherwise access in cities as well.

Situation of legal migrants from the United States. Mexico has 462,000 residents who are foreign born, totaling 0.54% of the population.[11] These foreign-born residents are more prevalent in the northern and southern border states. Accordingly, the populations of Baja California and Tamaulipas are composed of 1.98% and 1.84% foreign born residents, while Quintana Roo and Chiapas are 1.50% and 1.74% foreign born. These figures support transborder migrant movements.

The legal migrant population linked to businesses totaled 14,801 people in 1994, of which 1,782 were family members. A total of 18,588 foreign born individuals received immigration status this year, in order to permanently reside in Mexico. Most of this population can be categorized as middle class, involved in the formal labor market and with access to private or social security health services. Seventy-six percent 76.3% of Northamerican executives who reside in Mexico have insurance policies for major health costs, 87% of which include all family dependents.

North American retirees who reside in Mexico are already an important population group, even though exact population figures are not available. In 1991 the U.S. Department of Health and Human Services (DHHS) reported 62,610 U.S. social security beneficiaries living in Mexico and 66,592 residents in Canada. A survey sample showed that their average age is 73 in Cuernavaca and 76 in Mexico City[12], 53% are male and 47% female. Only 51% live in Mexico all year round; the rest go back to their country of origin periodically. This population is concentrated in four cities: Mexico, Guadalajara, Cuernavaca and San Miguel Allende.

Various Mexican health insurance companies offer policies that cover major medical costs for this population. Such policies for individuals ages 25 to 64 include coverage up to $16,891 dollars, an annual premium of $84, and a $51 deductible. According to national health insurance companies, these policies do not cover a large number of retirees because they can not compete with the policies offered in the United States.

Despite the availability of private insurance, 65% of the retirees who obtain medical services in Mexico pay cash. Up to 8% utilize IMSS services through voluntary payment or by retiring from a national institution. Twenty-eight percent (28%) pay for medical services via American private insurance companies, which does not include Medicare that may only be used in Mexico in the case of emergency care.

In contrast, the same retiree population pays cash for service in the U.S only 17% of the time. Twenty-two percent (22.5%) of retirees are protected by Medicare, 14.1% combine Medicare and cash payment and the remainder utilize other private insurance combined with cash.

Tourists. In 1994, Mexico received a total of 6,006,362 tourists who stayed more than 24 hours.[13] The Department of Tourism also registered more than 65 million sightseers who visited the border. Sixty percent (60%) of tourists entered through border ports of entry. Eighty-two percent (82%) of tourists originated from the United States, with 41% from California or Texas, and 41% from other parts of the U.S. Only 4% of tourists were from Canada and 14% from other countries. A total of 1,739,561 Mexican tourists entered other countries, especially the United States.

Despite the importance of international tourism for Mexico, the Department of Tourism does not record figures that monitor the health problems that this population faces. The only source of health information available to the tourist or foreign visitors is through embassies. This information is limited to recommendations regarding the best private hospitals in major cities throughout the country.

Most of the tourists that enter Mexico by automobile acquire insurance that includes coverage for medical costs in case of an automobile accident. The Mexican pay freeways also include accident insurance with limited medical coverage.

Given the high number of border sightseers and tourists who use freeways, emergency medical services along the U.S.-Mexico border have been improved and are considered a priority by U.S. authorities. Several temporary and immediate collaboration programs exist for this reason.

Although limited, the permanent programs include agreements for the transfer of patients across the border. The temporary programs consist of seminars and emergency medical services training, as well as the identification of problems that can be solved through the increase of binational collaboration.

Emerging Health Policies

Public policies. The administration of President Ernesto Zedillo has proposed to consolidate Mexico's economic expansion within the framework of NAFTA. This orientation assumes the wellbeing of the Mexican people as a high priority. To accomplish this, two general aspects of public health need to be strengthened: 1) the efficiency and quality of public and private health services, and 2) health service availability for all Mexicans.

During his campaign, President Zedillo referred to the health context of NAFTA, warning about the possible risks involved in the transfer of unhealthy technology from the U.S. and Canada to Mexico. Such technology transfer could have negative repercussions for Mexican workers.

> "The process of commercial expansion should stimulate us to take actions which will prevent our country from placing Mexican workers at risk. The health of our workers has no price." (E. Zedillo Speech, National Health and Social Security Forum, Mexico, D.F., July 24, 1994.)

In his speech, Zedillo announced important reforms in all aspects of the country's public health, favoring improvements in the equity of access, in service efficiency and in service quality. The possible separation between service operation and financing was mentioned, as well as the establishment of a package of essential services to which Mexicans would have universal access.

To date, the Zedillo government has operationalized the decentralization of health services, granting greater power to state governments to manage service financing and delivery. Major economic incentives have been introduced for rural doctors and a basic package of services was designed to guarantee universal care.

As previously mentioned, IMSS is undergoing reform to a major decentralization, a decrease in employers' fees for medical insurance, an increase in federal subsidy and strengthened participation of private lenders. In conjunction, it is expected that IMSS voluntary affiliation will expand, that an increase in jobs will augment obligatory insurance, and that increased competition for services will reduce costs.

North American health sector response to NAFTA.[14] The signing of NAFTA has stimulated interest on the part of North American health businesses. This interest includes suppliers of products, instruments, and equipment; auxiliary services; and medical insurance. This paper's focus will be limited to the supply of professional personnel.

North American medical businesses have demonstrated a greater interest in major Mexican cities than in border city markets. New investments have begun to strengthen the ties between professionals on both sides of the border.

New investments are characterized by binational capital and knowledge contributions, instead of the previous North American-oriented NAFTA efforts that probably failed due to a unilateral approach . The pattern that seems to prevail is the establishment of collaborative agreements for: 1) specialist consultancies via telecommunications; 2) the adoption of North American measures and procedures in order to elevate professional capacity, technical quality and prestige of new hospitals owned by Mexicans; and 3) the referral of patients to tertiary care units in the U. S.

Mexican private provider response to NAFTA. NAFTA has stimulated the organization of private doctors in Mexico, especially along the border. The major interest on the Mexican side of the border is explained by the high interdependency that professionals in this region have with patients who reside in the U.S. and cross the border for services. In effect, service exportation represents more than one fifth of the total income for Mexican doctors and dentists from principal border cities.[15] This trend is due to the fact that similar services in the U.S. cost 120% to 180% more than in Mexico. These services are favorable, especially for the Hispanic clientele who lack medical insurance in the U.S. Hispanics comprise three quarters of the foreign clientele treated in border cities.

The principal challenges that NAFTA presents for Mexican physicians revolve around their ability to increase productivity, prestige, technical organization and capacity. Only then can they compete with the North American businesses that come to Mexico to exploit this market. In order to expand the markets, it will be necessary to promote corporate associations similar to the health maintenance organizations (HMO's) in the United States and abandon the individual provider model within which about 80% of the private doctors practice. The need for technical training is reflected by the fact that 40% of doctors along the border can not find the specialists needed to satisfy the demand of foreign clients. Those with specialty training are often not up-to-date. In addition, 60% of the professionals along the border can not speak English.

Regulatory agency response to NAFTA. Private doctors, as well as the government, have recognized the need for a major reorganization and regulation of their professional practice in order to take advantage of NAFTA. There is a consensus that this regulation needs to be implemented internally through their own professional associations. Specialists are currently regulated by their specialist boards, nevertheless, the general practitioner lacks an organization that will oversee and promote contemporary practices. The new Mexican Board of Certification will begin to respond to these challenges. Municipal and state medical colleges, through the National Association of Medical Colleges (ANACOME), will also seek to elevate the professional level of general

practitioners. ANACOME has been recognized by the government to represent physicians before NAFTA.

With respect to medical schools, the National Association of Universities and Higher Education Institutes (ANUIES), has initiated the certification of medical schools, supporting the proposal of the Mexican Association of Faculty and Medical Schools for accreditation of schools.

The National Academy of Medicine has established relationships with its counterparts in the United States and Canada (the Institute of Medicine (IOM) in the United States) to complete a series of studies that will demonstrate the best way to streamline health regulation in the three countries. To date, several projects have explored institutional and legal frameworks of the three systems, service exchanges and challenges for the future. Work is currently being conducted to identify specific analysis projects and trend studies to support collective actions. The U.S.-Mexico border is a region which deserves special support from both the Mexican Medical Association (ANM) and the U.S. Institute of Medicine (IOM).

CONCLUSIONS

Mexico's National Health System has developed an ample service infrastructure in the past fifty years which benefits both the private and public sectors. Although great advances have been achieved in terms of legal service coverage, important gaps still remain, along with access barriers and population dissatisfaction. Private medical practice has grown in a disorderly fashion, meeting demand in some cases, but providing questionable quality at very high prices.

The Mexican Institute of Social Security (IMSS) has implemented programs to increase service coverage to international migrant workers and their dependents. These programs are based on a concern for the health of these Mexican citizens, but also take advantage of the ability to generate resources which help expand domestic coverage. Program results have not met expectations in terms of the percentage of migrants covered, however.

IMSS law includes the possibility of extending social security benefits to independent and agricultural workers. IMSS is currently assessing the possibility for turning this into a reality.

SSA offers a service model based on primary care, however, a substantial portion of the population that is entitled to services does not receive these benefits. Eight to twelve million Mexicans, according to various calculations, cannot even aspire to obtain basic services. The need to substantially increase service delivery efficiency is evident, allowing for greater autonomy and offering incentives that will allow providers to adequately target population.

Private services have great potential to improve wellbeing in Mexico, as well as to positively contribute to the economy. Nonetheless, a lack of regulation and proper investment are also possible threats within the growth context of NAFTA. In fact, as North American markets pressure inefficient Mexican health services and insurance companies out, foreign companies are likely to seek permanent opportunities in Mexico. Mexico must anticipate this pressure and offer incentives that will drive private, national and foreign investments in a direction that will complement public policy. One half of the national health expenditure is now within the private sector.[16] As long as this expenditure is not efficiently directed, the private sector will fail to positively contribute to the country's economic growth as a whole.

The great number of tourists and business people expected to enter the country through NAFTA also necessitates improved health care access, particularly regarding emergency medical services. These services are inefficient in Mexico due to a lack of the coordination necessary to guarantee a fast, high quality response. The quality of those services which particularly impact the health of tourists must also be improved. Offering special services could create a better tourist environment.

It is evident that additional aspects of private and public medicine need greater attention concerning North American business people and retirees.

The three principal cities in the border region have the highest socioeconomic level in the country, but the percentage of the population covered by social security is lower. Health conditions are significantly superior at the border when compared to the rest of the country. One third as many border residents consider their health poor, one half have some sort of disability, and one fourth have been hospitalized, when compared to residents from the rest of the country.

Demand for services is more effectively met at the border, where 28% fewer patients express unmet need when compared to national figures. Organizational barriers have the greatest impact on the border population. A lack of economic resources is the greatest barrier to health access nationwide, which is a more difficult barrier to overcome.

Despite better health service availability, access and greater patient satisfaction along the border, adults in this region demand fewer preventive, outpatient and hospital services. This situation is likely associated with better health conditions along the border. Elevated injury and chronic disease rates imply a greater need for the border population to use health services, especially for early detection.

Table 1

Legal Coverage of the Mexican Population by Institution, 1990*

COVERAGE	Total	%
Social Security	44,627,508	55
SSA/IMSS-Sol	27,587,913	34
Uninsured	8,925,501	11
Total	81,140,922	100

Table 2

Barriers to Access to Medical Services According to Coverage Status

	COVERAGE		
BARRIER	Insured	Uninsured	TOTAL
Economic	23	49	43
Geographic	53	39	42
Organizational	24	12	15
TOTAL	100	100	100

Source: National Health Survey. Mexico City, SSA 1988.

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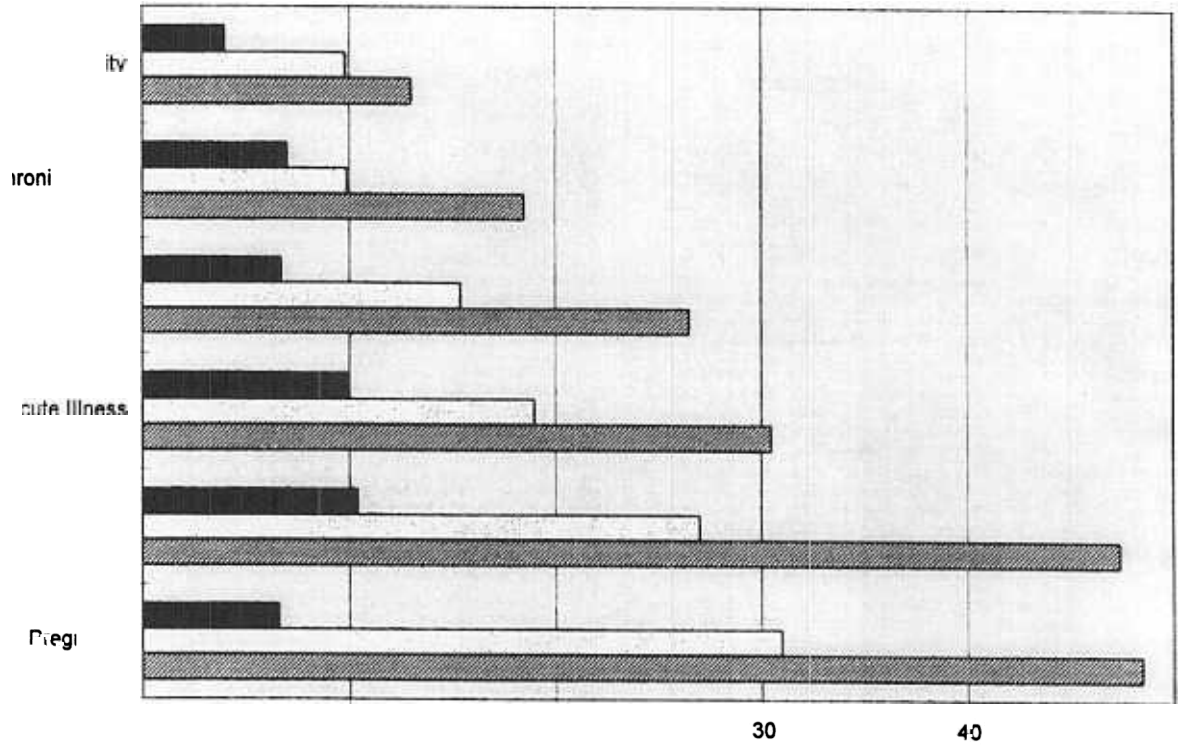

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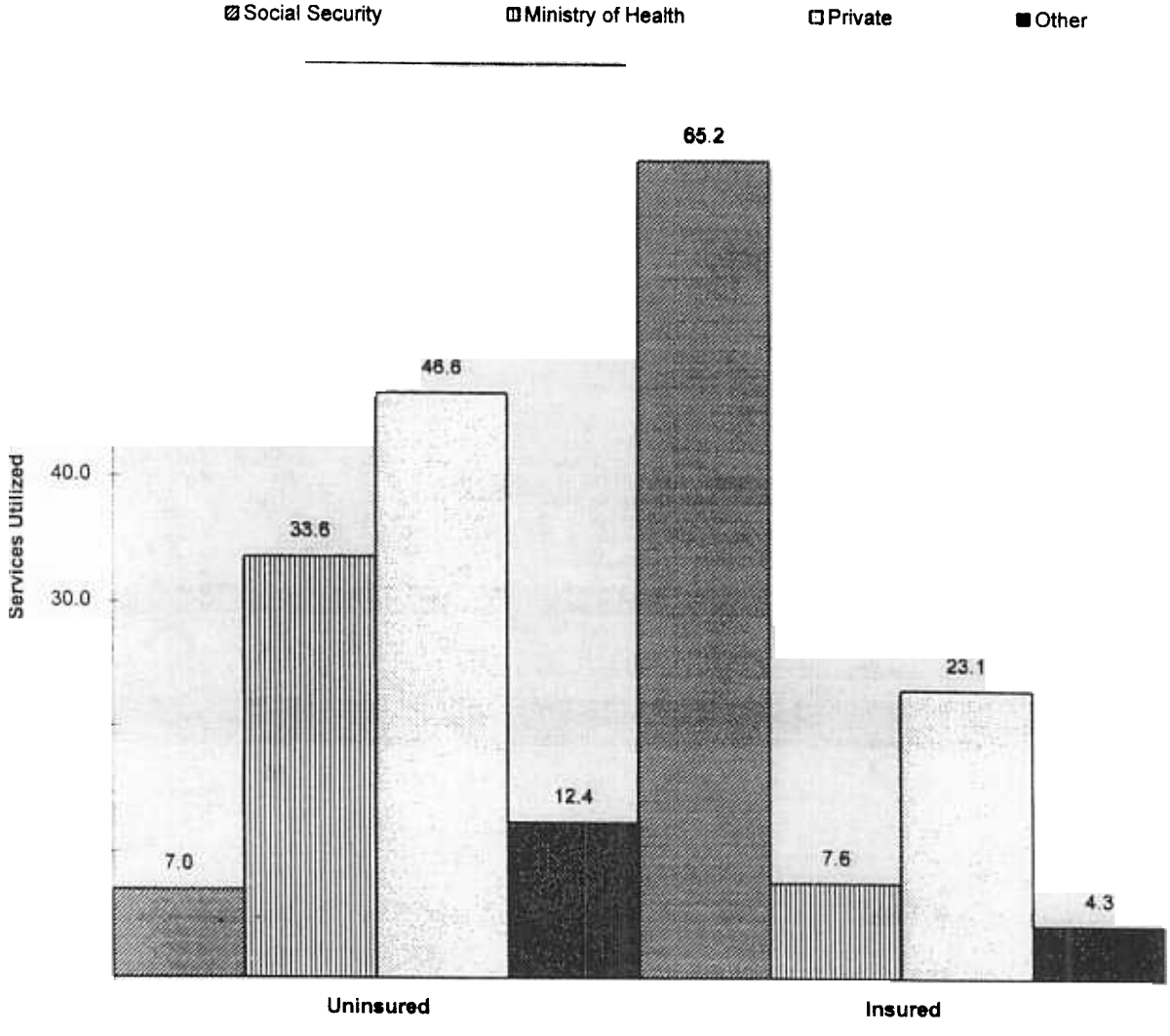
Figure 2

Utilization of Health Services
by Legal Social Security Coverage



Source: SSA, National Health Survey II.

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1) The information about the social security coverage is based on the National Health Survey II (SSA, ENSA II, Mexico, 1994). The official statistics are less precise: for instance, when the coverage of the social security and the assistance services reported by them are added up, the total obtained exceeds 100% of the population.

2) The official estimates are much more optimistic, since they analize the coverage based on resources and types of attention, under productivity considerations which result more favorable. Thus, SSA estimated a potential coverage of 42 million people for 1992, and the social security reports 47.4 million covered people. This results in a total of 89.4 million covered people. This amount exceeds the total population nationally, and it refers to service coverage in outpatient consultation, considering the rural areas of every state. See Lozano R., Infante C., Schlaepfer L. and Frenk J. Desigualdad, pobreza y salud en México. México, D.F.: El Nacional, 1993:148.

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SSA, National Health Survey II (graphics), Mexico, SSA, 1994

4) SSA, Encuesta Nacional de Salud II (graficos), México, SSA, 1994
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5) This is very tentative data, since I just captured 15 individuals from the survey in this situation.

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14) We appreciate Cristina Von Glascoe's permission to use some research results of the "La Salud Materno-Infantil y el Tratado de Libre Comercio en la frontera Norte de México" project. This project is being funded by a grant from the Pew Charitable Trusts to La Fundacion Mexicana para la Salud (Mexican Health Foundation).

15) Zepeda, E. Mercado local y comercio transfronterizo de sevicios profesionales en la frontera norte: una visión sintética. Tijuana, El COLEF, 1994.
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